HIV/STD OPERATIONS MANUAL
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Division of HIV/STD
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June 20, 2001

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- Information
- Literature Requests

DIVISION OF HIV/STD

Mission Statement

The mission of the Division of HIV/STD is to support health districts/departments and non-governmental organizations in the prevention and treatment of HIV and other STDs, including their complications, through provision of education, information, and health care services that promote and protect the health of all Virginians.

Long-term Objectives

Following are the Virginia Department of Health long-term objectives for specific STDs and HIV health care services. A list of comparable national Healthy People 2000 Objectives is attached.

HIV

1. By the year 2004, the annual case rate per 100,000 for HIV will be no more than 6.2 (Baseline: 12.21 case rate/100,000 for 1998)

2. By the year 2004, increase the number of persons who return for HIV test results and post-test counseling to no less than 75% for seronegatives and 90% for seropositives. (Baseline: 32% for seronegatives and 46% for seropositives in 1998)

Syphilis

1. By the year 2004, primary and secondary syphilis will be reduced to an incidence of no more than 1 case per 100,000 population. (Baseline: 2.2. infections per 100,000 Population in 1998)

2. By the year 2004, congenital syphilis will be eliminated. (Baseline: 5 cases in 1998)

Chlamydia

By the year 2004, reduce the prevalence of Chlamydia trachomatis infections among women to no more than 2 percent. (Baseline: 7.4 percent in 1998)

Gonorrhea

By the year 2004, gonorrhea infections will be reduced to no more than 100 infections per 100,000 population. (Baseline: 136.3 infections per 100,000 population in 1998)

HIV Health Care Services

By March 31, 2000, increase by 10% the number of consumers receiving primary medical care with Ryan White Title II funding. (Baseline: 859 clients).

HEALTHY PEOPLE 2010 OBJECTIVES

1. (Developmental) Confine the prevalence of HIV infection.

2. (Developmental) Increase the number of HIV-positive persons who know their serostatus.

3. Reduce primary and secondary syphilis to an incidence of no more than 0.2 cases per 100,000 people.

4. Reduce congenital syphilis to an incidence of no more than 1 new case per 100,000 births.

5. Reduce the prevalence of Chlamydia trachomatis infections among young women (under the age of 25 years) to no more than 3.0 percent.

6. Reduce Gonorrhea to an incidence of no more than 19 cases per 100,000 people.

MAIL THE TOP TWO COPIES TO YOUR LOCAL HEALTH DEPARTMENT

VIRGINIA DEPARTMENT OF HEALTH
Confidential Morbidity Report

Patient's Name (Last, First, Middle Initial):

SSN: _____-_____-_____

Home #: ( ) _____-_____

Work #: ( ) _____-_____

Patient's Address (Street, City or Town, State, Zip Code):

City or County of Residence

Date of Birth:	Age:	Race: ❑ Asian/Pacific Islander ❑ White ❑ Black ❑ Other (specify):	Hispanic: ❑Yes ❑ No	Sex: ❑ F ❑ M

DISEASE OR CONDITION:	Case Status: ❑ Confirmed ❑ Suspected	Date of Onset:

Date of Diagnosis:	Death: ❑ Yes ❑ No Death Date:	Influenza: (Report # and type only. No patient identification). Number of Cases: Type, if known:

Physician's Name: Phone: ( )

Address:

Hospital Admission? ❑ Yes ❑ No Hospital Name:

Date of Admission: Chart ID No:

Laboratory Information and Results

Source of Specimen: Date Collected:

Laboratory Test:

Results:

Name/Address of Lab:

CLIA Number:

Other Information

Comments: (E.g., Risk Situation [Food Handling, Patient Care, Day Care], Treatment [including dates], Immunization Status [including dates], Signs/Symptoms, Exposure, Outbreak Associated, etc.)

For Health Department Use: Date Received:

Name, Address, and Phone Number of Person Completing This Form:

Date Reported:

Check here if you need more of these forms, or call your local health department. (Be sure your address is complete.) ☐

Please complete as much of this form as possible.

Form Epi-1, 11/98

HIV/STD REPORTING GUIDELINES

Commonwealth of Virginia, Virginia Department of Health
January 1, 1999

Why is Disease Reporting Important?

Surveillance Data are necessary to:

* Monitor Disease Trends
* Target Prevention Efforts
* Plan for Health Care Needs
* Allocate Resources

Underreporting hinders Virginia's HIV/AIDS and STD programs because funding is awarded based upon the number of cases reported.

When Should You Report Syphilis?

Primary and Secondary must be reported within 24 hours by the most rapid means. All other stages must be reported within 7 days.

When Should You Report Cases of HIV/AIDS?

Providers should report all HIV positive individuals. Numerous cases of HIV/AIDS have been overlooked because providers assumed that individuals were previously reported. **If in doubt, *REPORT!***

HIV or AIDS Reporting Guidelines:

- HIV infection and AIDS are **separate** reportable conditions in Virginia.
- HIV diagnosis is based on a positive laboratory result.
- AIDS cases are classified by a documented HIV infection and either :
  1) a CD4 count *<200/μl or <14%, or*
  2) the diagnosis of an opportunistic infection.
- Report HIV/AIDS and STDs to your **local health department.**
- Reportable HIV/AIDS tests now include positive results for blood **and body fluids**.

Resources:

Your local health department provides information and technical assistance, and assists with reporting HIV/AIDS and STDs.

General information is also available from the **HIV/STD Hotline: 1-800-533-4148.**

COMMONWEALTH of VIRGINIA

E. Anne Peterson, MD, MPH
State Health Commissioner

Department of Health
P O BOX 2448
RICHMOND, VA 23218

TDD 1-800-828-1120

October 8, 1999

MEMORANDUM

To: **District Health Directors**
HIV/STD Supervisors and Counselors

From: **Casey W. Riley, Director**
Division of HIV/STD

Subject: **Division of Consolidated Laboratory Services HIV-1 Positive Laboratory Reports**

The procedures outlined below are being recommended to ensure that confidential HIV-1 positive test results from the Division of Consolidated Laboratory Services (DCLS), receive follow up. The implementation of these procedures will also assist in determining a more accurate positivity rate and positive post-test counseling return rate on the local, district and state levels. Statewide, post test counseling return rates for 1998 are below 50% and our positivity rate has been less than 1% for several years. The following procedures have been successfully piloted in the Eastern Epidemiology Field Office for over a year.

Summary of reactive DCLS, confidential HIV-1 laboratory reports procedures - Effective November 1, 1999:

1. All DCLS confidential HIV-1 positive laboratory reports should be initiated on a four-part field record (FR). The pink copy of the initiated FR should be forwarded to the HIV/AIDS Surveillance Unit for all newly tested positive reactors, and a four- part FR (in total) should also be forwarded for previously positive reactors. The HIV/AIDS Surveillance Unit will contact the local level representative, when an EPI-1 and a pink field record copy on new positive reports, or a closed field record for previous positive reports are not received, to request a FR number.

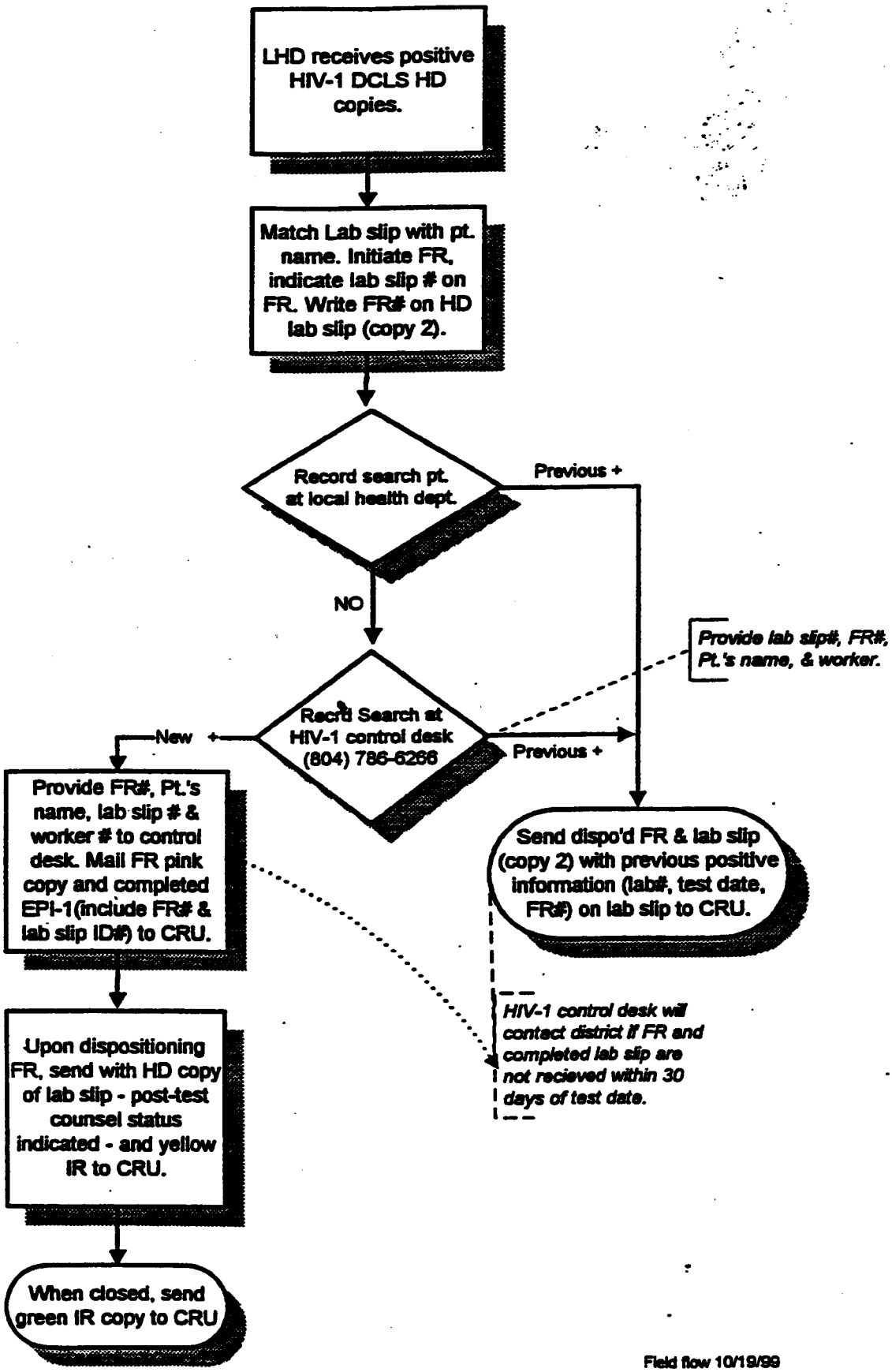
2. At the close of the field investigation, the local level representative should forward the closed white FR, the completed HIV-1 laboratory slip, and the yellow copy of the interview record (IR) to the HIV/AIDS Surveillance Unit. The closed green IR should be forwarded following the end of case management activities.

3. The HIV-1 laboratory number should be written on the field and interview records, and the EPI-1 before forwarding the reports to the HIV/AIDS Surveillance Unit, this will assist in quality assurance.

Thank you for your cooperation in this matter.

/pkt

Positive HIV-1 Confidential DCLS Report



Field flow 10/19/99

COMMONWEALTH of VIRGINIA

E. Anne Peterson, MD, MPH
State Health Commissioner

Department of Health
P O BOX 2448
RICHMOND, VA 23218

TDD 1-800-828-1120

February 4, 2000

MEMORANDUM

TO: **HIV/STD Supervisors/Managers**

FROM: **Casey W. Riley, Director**
Division of HIV/ STD

SUBJECT: **Documentation of Program Activities (Revision of 2/23/93)**

The following activities should be conducted to assure high quality and accurate techniques are used in the performance of field activities, prevention counseling, interviewing, and case management skills. These standards should be performed by supervisors and considered routine procedures for assessing and documenting HIV/STD program activities for each HIV/STD health counselor and nurse.

1. Pouch reviews should be conducted weekly for newly hired employees and employees identified as having performance problems, and monthly for all other health counselors and public health nurses (if applicable).

2. Skills inventories for partner counseling and referral services, prevention counseling, syphilis, gonorrhea, and chlamydia interviews or other STD counseling, and field investigation activities should be conducted monthly for newly hired employees and those identified as having performance problems. Quarterly or semi-annually skills inventories should be conducted for all other health counselors and public health nurses. (See attached memorandum dated April 4, 1990).

3. Interview records should be reviewed for accuracy, and recommendations for case management should be developed, and documented with appropriate follow up performed as needed. Case management recommendations and or problems should be discussed, and documented with the employee in a timely manner.

4. The supervisory "open field record control box" should be reviewed weekly and the status of outstanding field records should be discussed with the appropriate health counselor or public health nurse.

5. The criteria for diagnosing a patient as early latent syphilis of less than one-year duration should be utilized in all areas. (Memorandum dated 4/28/83). The criteria are as follows:

   a. history of symptoms that are compatible with primary or secondary syphilis or,
   b. a rapidly rising titer or,
   c. history of a negative titer in the past year or,
   d. an epidemiologic link to a known case.

All early cases must meet at least one of the stated criteria. Follow up must be performed on cases that appear to be early syphilis, because of age, titer or other condition. In this instance, epidemiologic investigation should be performed prior to morbidity being reported as early latent syphilis under one year.

6. All investigative and follow-up activities should be conducted on the official four-part field record.

7. Open and closed interview and field records should be filed in a manner that will facilitate easy retrieval.

Documentation of activities saves time and can assist in our prevention efforts when conducted on a consistent basis. These documents also provide the legal basis for which follow-up, counseling, and partner referral can be initiated and their outcome substantiated. Documentation and the performance of program activity reviews are the only record that can account for the health counselor and nurses time and effort, as well as the quality of supervisory involvement.

Attachments

COMMONWEALTH of VIRGINIA

Department of Health
P O BOX 2448
RICHMOND, VA 23218

E. Anne Peterson, MD, MPH
State Health Commissioner

TDD 1-800-828-1120

February 7, 2000

MEMORANDUM

TO: **Anonymous Test Site (ATS) Clinic Directors**
HIV/STD Supervisors and Counselors

FROM: **Casey W. Riley, Director**
Division of HIV/STD

SUBJECT: **HIV Partner Counseling and Referral Services (PCRS) in ATS**
(Revision of 2/12/94)

Procedures for HIV Partner Counseling and Referral Services in ATS are as follows:

1. The HIV positive client should be encouraged to enter a confidential setting in order to benefit from medical and other intervention services. The HIV positive client may be provided a list of referral options or assisted in scheduling an appointment.

2. The HIV positive client should be informed about the approaches used in PCRS.

    a. If the individual requests client or dual partner referral options in the ATS, the ATS counselor, and the HIV infected client should thoroughly examine the potential benefits and consequences of using these types of referral. Clients testing anonymously through client or dual referral approaches should be documented as a partner referral on the HIV-1 laboratory slip.

    b. If the client requires direct assistance from the health department (provider referral), the ATS counselor should initiate a field record (FR). The HIV-1 patient number should be used as the original patient identification number. In order to initiate the FR (see attachment), the counselor will need to gather locating, exposure and other descriptive information about the sex or needle sharing partner. The counselor must also explain that the health department may contact the ATS client (original patient) as part of the process if a positive partner names the original patient. The counselor and patient need to develop a plan on how the ATS client will handle the situation if this should occur.

3. The entire FR must be forwarded to the local health department for follow up.

4. An EPI 1 is not required, because ATS are exempt from reporting by name HIV positive clients.

/pkt

Posted Notice of "Deemed Consent" To HIV Testing In Exposure Incidents

Suggested by AIDS Committee, Office of the Attorney General August 17, 1989

As a health care provider, we are required by section 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice.

1.

If one of our health care professionals, workers, or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus ("HIV," the "AIDS" virus) and for the presence of the hepatitis B and hepatitis C viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.

2.

If you should be directly exposed to blood or body fluids of one of our health care professionals, workers, or employees in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus ("HIV," the "AIDS" virus) and for the presence of the hepatitis B and hepatitis C viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.

Health Department/Center

CONSENT TO TEST FOR ANTIBODIES TO THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

Information:

It is important for you to have a blood test to detect the presence of antibodies to the virus that causes the disease AIDS known as the Human Immunodeficiency Virus (HIV).

This procedure is performed as any routine blood test, by withdrawing a small amount of blood from the vein by needle.

This testing is important to insure that adequate precautions can be taken to prevent transmissions of the virus to others should the results be positive and to help prevent future infections from the virus if the test is negative.

This testing is also important for your health care, if the test results are positive, so that the best available treatment may be provided as early in the stages of the disease as possible. Periodic follow-up tests will be performed as determined appropriate by the physician.

You will be informed of the results of the test and receive counseling and/or education concerning the AIDS virus. The results of the test will not be disclosed to anyone except persons authorized by law to receive such information. Such persons are required by law to keep the information confidential. All positive test results will be disclosed to the Department of Health. Other persons to whom the results may be disclosed include health car providers involved in your care or treatment, emergency medical services personnel, others who have access to the record for quality assurance, your parents(s) if you are a minor, or your spouse.

Consent:

I have received information about AIDS and AIDS (HIV) testing. I understand that the testing is recommended and that the results will remain confidential and will be provided to health care providers and others only as necessary. I further understand that this consent may be revoked in writing prior to the drawing of blood for further tests.

_____ I consent to performance of the AIDS (HIV) antibody test and such periodic tests as the physician determines appropriate.

_____I do not consent to performance of the AIDS (HIV) antibody test.

SIGNED:_____DATE:_____

WITNESS:_____DATE:_____

_____
Health Department/Center

CONSENT TO ORAL TEST FOR ANTIBODIES TO THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

INFORMATION:

It is important for you to have an oral test to detect the presence of antibodies to the virus that causes the disease AIDS, known as the Human Immunodeficiency Virus (HIV).

This procedure is performed by placing a special pad with a handle between your cheek and gum for two minutes.

This testing is important to insure that adequate precautions can be taken to prevent transmission of the virus to others should the result be positive and to help prevent future infection from the virus if the test is negative.

The testing is also important for your health care, if the test results are positive, so that the best available treatment may be provided as early in the stages of the disease as possible. Periodic follow-up tests will be performed as determined appropriate by the physician.

You will be informed of the results of the test and receive counseling and/or education concerning the AIDS virus. The results of the test will not be disclosed to anyone except persons authorized by law to receive such information. Such persons are required by law to keep the information confidential. All positive test results will be disclosed to the Department of Health. Other persons to whom the results may be disclosed include health care providers involved in your care or treatment, emergency medical services personnel, others who have access to the record for quality assurance, your parent(s) if you are a minor, or your spouse.

CONSENT:

I have received information about AIDS and AIDS (HIV) testing. I understand that the testing is recommended and that the results will remain confidential and will be provided to health care providers and others only as necessary. I further understand that this consent may be revoked in writing prior to the collection of oral specimens for future tests.

_____ I consent to performance of the AIDS (HIV) antibody test and such periodic tests as the physician determines appropriate.

_____ I do not consent to performance of the AIDS (HIV) antibody test.

Signed: _____ Date_____
Authorized Representative/Guardian

Witness: _____ Date_____

(OMT REV 4/00)

COMMONWEALTH of VIRGINIA

Department of Health
P O BOX 2448
RICHMOND, VA 23218

TDD 1-800-828-1120

February 7, 1990

VIRGINIA DEPARTMENT OF HEALTH GUIDELINES FOR PREVENTING BLOODBORNE INFECTIONS IN SCHOOLS - SUPPLEMENT TO SUPTS. MEMO NO. 255, OF NOVEMBER 29, 1989

Because the blood and certain body fluids (semen and vaginal secretions) of all persons must be considered potentially infectious for human immunodeficiency virus, hepatitis B, and other organisms, it is important to follow precautions. Fortunately, in the case of schools, one need only be concerned about blood. Universal precautions do not apply to feces, nasal secretions, saliva sputum, sweat, tears, urine, and vomitus unless they contain blood. Despite the extremely remote risk that exposure of skin to blood could result in infection (the unabraided skin is an excellent defense against bloodborne organisms), the following precautions should be adhered to without any exceptions:

1. Those involved in cleaning surfaces contaminated with blood or rendering first aid to bleeding children should wear disposable gloves and avoid exposure of open skin lesions and mucous membranes to blood.

2. Surfaces contaminated with blood should be promptly cleaned with household bleach (1 part bleach to 9 parts water) using disposable towels or tissues.

3. Hands must be washed after gloves are removed.

4. If inadvertent contamination of the skin with blood were to occur, all that is required is thorough washing of the contaminated areas with soap and water.

MODEL GUIDELINES FOR SCHOOL ATTENDANCE FOR CHILDREN WITH HUMAN IMMUNODEFICIENCY VIRUS

The _____Public School Division will work cooperatively with the _____Health Department to ensure compliance with the Virginia Code 22.1-271.3 for school attendance of children infected with human immunodeficiency virus (HIV).

A. Students are expected to be in compliance with an immunization schedule (Article 2, 22.1-271.2); however, some required immunizations may be harmful to the health of the student who is HIV infected or has AIDS. Students who are HIV infected or have AIDS may get an exemption from complying with the requirements (Virginia Code 22.1-27.2, C). School personnel will cooperate with public health personnel in completing and coordinating immunization data, exemptions, and exclusions, including immunization forms.

B. Mandatory screening for HIV infection is not warranted as a condition for school entry. Upon learning a student is HIV infected or has AIDS, the superintendent will consult with the individual's family and physician or a health official from the local health department to determine whether the student is well enough to stay in school. Since it is known that HIV is not transmitted through casual contact, any student who is HIV infected will continue education in a regular classroom assignment unless the health status interferes significantly with performance. If a change in the student's program is necessary, the superintendent or designee, family, and physician or health official will develop an individual plan which is medically, legally, and educationally sound. If the HIV student is receiving special education services, the services will be in agreement with established policies.

C. Parents/guardians may appeal decisions for restriction or exclusion as determined by the School division's established procedures.

D. All persons privileged with any medical information about HIV infected students shall be required to treat all proceedings, discussions, and documents as confidential information. Individuals will be informed of the situation on a "Need to Know" basis with written consent of the parent/guardian.

E. Universal precautions for handling blood will be implemented within the school setting and on buses. To ensure implementation of the proper standard operating procedures for all body fluids, the guidelines from the Virginia Department of Health will be followed. In-service training will be provided to all school personnel. Training will include local division policies; etiology, transmission, prevention, and risk reduction of HIV; standard operating procedures for handling blood and body fluids; and community resources available for information and referral. Periodic updates will be supplied through in-service or memoranda.

F. Comprehensive and age-appropriate instruction on the principal modes by which HIV is spread and the best methods for the reduction and prevention of AIDS are required to encourage the support and protection of the HIV infected student. To enhance school attendance, the school division will collaborate with public and private organizations in the provision of support services to HIV infected students.

COMMONWEALTH of VIRGINIA

Department of Health
P O BOX 2448
RICHMOND, VA 23218

RANDOLPH L. GORDON, M.D., M.P.H.
COMMISSIONER

TDD 1-800-828-1120

June 27, 1997

MEMORANDUM

TO: District Directors

FROM: Grayson B. Miller, Jr., M.D.
Director, Office of Epidemiology

SUBJECT: HB 2764: Bloodborne Pathogen Training for School Personnel And Management of Exposure-Prone Incidents in Schools

The 1997 General Assembly amended Sections 22.1-271.3 of the Code of Virginia to 1) require school boards to ensure that school personnel who have direct contact with students receive bloodborne pathogen training and 2) require local health directors to provide medical advice to division superintendents regarding possible exposures of school personnel to blood or body fluids of students. Attachment I is a copy of that amendment.

While school boards are responsible for the provision of bloodborne pathogen training to school personnel, school systems are likely to request your assistance. It may be helpful for you to be involved at least in the planning stages for this training. Involvement of local health departments may ensure that school employees receive the correct messages about potential risks and legitimate modes of disease transmission, thereby decreasing the number of calls regarding incidents which do not pose exposure risks to personnel.

All school districts and health districts were previously provided with the manual Guidelines for Specialized Health Care Procedures. Attachment II is a section from those guidelines entitled "Guidelines Regarding Bloodborne Pathogens." This information should be helpful for school personnel involved in training.

The law also requires that a school superintendent consult the local health director for situations involving incidents which may have exposed employees to the blood or body fluids of students. You should meet with the division superintendent(s) to work out notification procedures for your district.

The district director is responsible for investigating each exposure incident as soon as practicable to determine the appropriate recommendation for the employee. There is no prescribed method or format for the investigation. It need be no longer or more detailed than is necessary to ascertain the degree of risk to the employee. The investigation may be conducted as a telephone interview with a public health or school nurse, as well as the school superintendent, who has determined the essential facts of the exposure incident. This telephone interview may be sufficient to develop recommendations for the superintendent. The medical advice may be conveyed to the school by the district director or another health department physician. The medical advice should be provided to the school superintendent, not the employee. It is the responsibility of the school superintendent to convey the information to the employee.

There is no responsibility on the part of the health department to provide diagnostic services or treatment. The goal of the recommendation is 1) to apprise the employee of the degree of risk that he or she has been infected by a bloodborne pathogen, and 2) to suggest a course of action, if any, the employee should consider. The course of action may address diagnostic, prophylactic, preventive, or treatment actions. These services may be provided by the health department, the employee's health care provider, or a combination. For assistance in determining recommendations, you may want to review Dr. John Rullan's memorandum of September 25, 1996, regarding post-exposure prophylaxis guidelines for occupational HIV exposure. As long as you have made a good faith effort to provide consultation and specific recommendations, you have discharged your responsibility under this law.

Based on past experience reported from selected health districts, we do not expect to have a large number of requests from school districts for assistance in exposure-prone incidents. In order to assess the demand and to provide you with help, I am asking that you track these requests, including how many requests were received, the average amount of district time spent on each request and how many of them were substantiated exposures. We will survey you at the end of the first year to gather these data. Please advise me if the requests become excessive.

Please remember that existing laws regarding release of confidential medical information are applicable, as are penalties for improper release of information. The Office of Epidemiology is available to assist you with the implementation of this law as needed. If you have any questions, please call me at (804) 786-6029 , Dr. John Rullan at (804) 786-6261 or Casey W. Riley at (804) 786-6267.

Attachments

c: Jeff Lake
John Rullan, M.D.
Casey W. Riley
Doug Cox

APPENDIX C: Universal Precautions and Infectious Diseases

- Universal Precautions
- Selected Infectious Diseases

Universal Precautions for Handling Blood/Body Fluids in School

Authorization

Occupational Safety and Health Administration (OSHA) Final Bloodborne Pathogens Standard. The following guidelines are designed to protect persons who may be exposed to blood or body fluids of students or employees in a school. Please refer to the Occupational Safety and Health Administration (OSHA) Final Bloodborne Pathogens Standard for the most recent requirements.

Overview

Anticipating Potential Contact. Anticipating potential contact with infectious materials in routine and emergency situations is the most important step in preventing exposure to and transmission of infections. Use universal precautions and infection control techniques in all situations that may present the hazard of infection. Diligent and proper handwashing, the use of barriers (e.g., latex or vinyl gloves), appropriate disposal of waste products and needles, and proper care of spills are essential techniques of infection control.

Applying the Concept of Universal Precautions. When applying the concept of universal precautions to infection control, all blood and body fluids are treated as if they contain bloodborne pathogens, such as the human immunodeficiency virus (HIV) and hepatitis B virus (HBV). HIV and HBV can be found in:

- blood
- spinal fluid
- synovial fluid
- vaginal secretions
- semen
- pericardial fluid
- breast milk
- peritoneal fluid
- amniotic fluid
- pleural fluid

Hepatitis B Virus (HBV). HBV (not HIV) is also found in saliva and other body fluids such as urine, vomitus, nasal secretions, sputum, and feces. It is not possible to know whether these body fluids contain bloodborne pathogens therefore, **all body fluids should be considered potentially infectious.** Thus universal precautions should be

observed by all students and staff when handling or coming into contact with any blood or body fluids.

Handwashing

Diligent and proper handwashing are essential components of infection control. Hands should be washed:

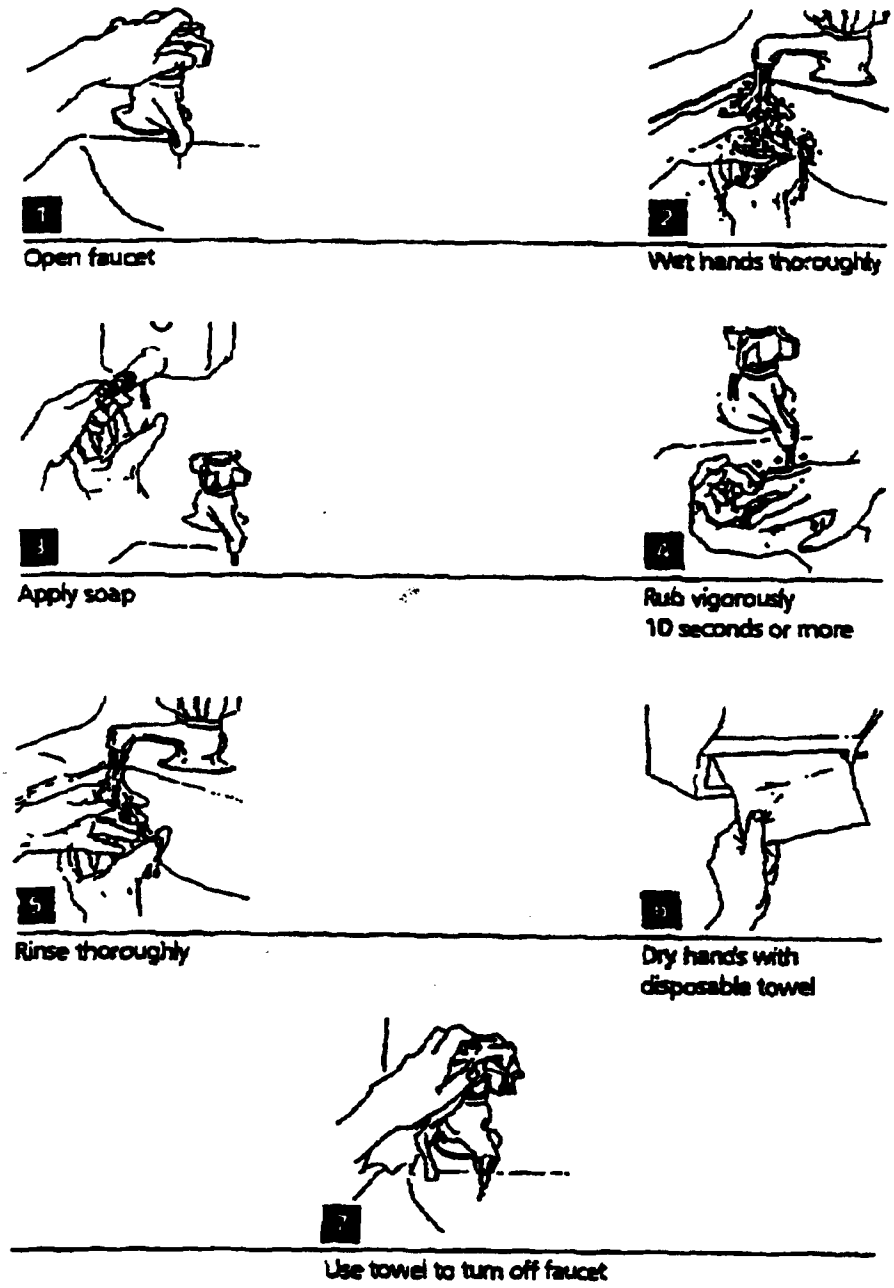
- Immediately before and after physical contact with a student (e.g., diaper changes, assisting with toileting, assisting with feeding).
- Immediately after contact with blood or body fluids or garments or objects soiled with body fluids or blood.
- After contact with used equipment (e.g., stethoscope, emesis basin, gloves).
- After removing protective equipment, such as gloves or clothing.

Procedure.

1. Remove jewelry and store in a safe place prior to initial handwashing (replace jewelry after final handwashing).
2. Wash hands vigorously with soap under a stream of running water for approximately 10 seconds.
3. Rinse hands well with running water, and thoroughly dry with paper towels.
4. If soap and water are unavailable, bacteriostatic/bactericidal wet towelettes, "handi-wipes," or instant hand cleaner may be used.

Please see detailed instructions in Figure 5., Eight Steps to Proper Handwashing, for detailed handwashing instructions.

Figure 5. Eight Steps to Proper Handwashing [133]



[133] From *Resource Manual for the Prevention of HIB/HBV Viruses* by Maryland State Department of Education, 1991.

Ways to Avoid Contact with Body Fluids

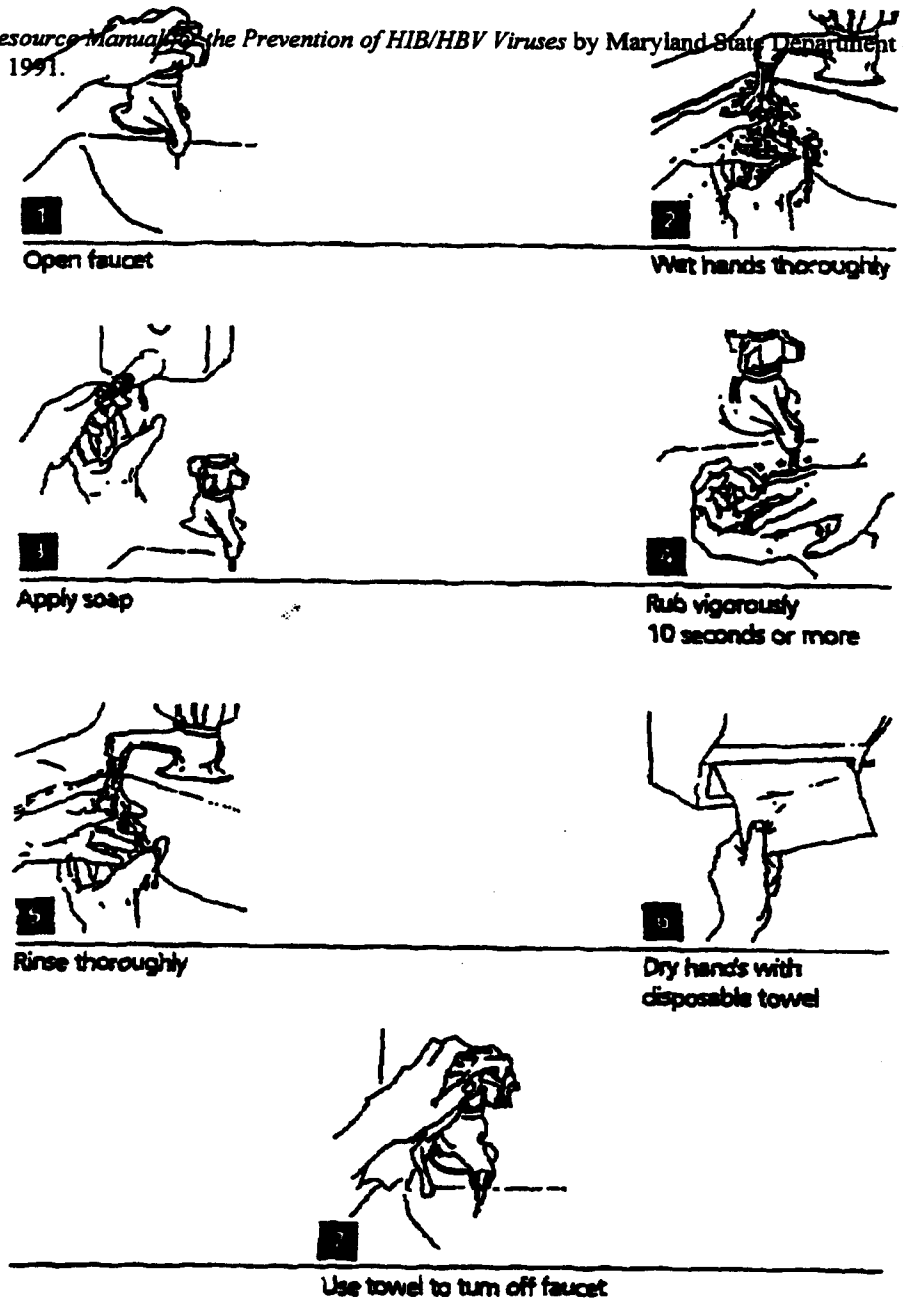
Gloves. When possible, avoid direct skin contact with body fluids. Disposable single use, waterproof, latex, or vinyl gloves should be available in school clinics. Vinyl gloves should be used with students who have a latex allergy or a high potential for developing a latex allergy, such as students with spina bifida. The use of gloves is intended to reduce the risk of contact with blood and body fluids for the caregiver as well as to control the spread of infectious agents from student to employee, employee to student, or employee to employee.

Gloves should be worn when direct care may involve contact with any type of body fluids. Incidents when gloves should be worn include (but are not limited to): caring for nose bleeds, changing a bandage or sanitary napkins, cleaning up spills or garments soiled with body fluids, disposing of supplies soiled with blood, or any procedure where blood is visible. Gloves should also be worn when changing a diaper, catheterizing a student, or providing mouth, nose or tracheal care.

Do Not Reuse Gloves. After each use, gloves should be removed without touching the outside of the glove and disposed of in a lined waste container. After removing the gloves, the hands should be washed according to the handwashing procedure. (See Figure 6., Proper Removal of Gloves.)

Figure 6. Proper Removal of Gloves [134]

[134] From *Resource Manual for the Prevention of HIB/HBV Viruses* by Maryland State Department of Education, 1991.



Protective Clothing. If spattering of body fluids is anticipated, the clothing of the caregiver should be protected with an apron or gown and the face protected with a face mask and eye goggles or face shield. The apron or gown should be laundered or disposed of after it is used and should not be used again until it is clean. The goggles and mask should be disposed of properly.

Shield for Rescue Breathing. If it is necessary to perform Rescue Breathing, a one-way mask or other infection control barrier should be used. However, Rescue Breathing should not be delayed while such a device is located.

Disposal of Infectious Waste

Contaminated Supplies. All used or contaminated supplies (e.g., gloves and other barriers, sanitary napkins, Band-Aids), except syringes, needles, and other sharp implements, should be placed into a plastic bag and sealed. This bag can be thrown into the garbage, out of reach of children or animals.

Used Needles, Syringes, And Other Sharp Objects. Make arrangements to dispose of used needles, syringes, and other sharp objects at a local medical facility or health department. Needles, syringes, and other sharp objects should be placed **immediately after use** in a metal or other puncture-proof container that is leak proof on the bottom and sides. To reduce the risk of a cut or accidental puncture by a needle, NEEDLES SHOULD NOT BE RECAPPED, BENT, OR REMOVED FROM THE SYRINGE BEFORE DISPOSAL. Once it is full, the container should be sealed, bagged, and kept out of the reach of children until it can be disposed of properly.

Body Waste. Body waste (e.g., urine, vomitus, and feces) should be disposed of in the toilet. If such body fluids as urine and vomitus are spilled, the body fluids should be covered with an absorbent sanitary material, gently swept up, and discarded in plastic bags.

Clean-Up

Spills of blood and body fluids should be cleaned up immediately with an approved disinfectant cleaner.

Procedure.

1. Wear gloves. (See "Ways to Avoid Contact with Body Fluids" on previous page.)
2. Mop up spill with absorbent material.

3. Wash the area well, using the disinfectant cleaner supplied in the clinics or a 1:10 bleach solution (mix 1 part household bleach, sodium hypochlorite, in ten parts of water). Replace solution daily.

4. Dispose of gloves, soiled towels, and other waste in sealed plastic bags and place in garbage, as already indicated.

5. WASH HANDS.

Routine Environmental Clean-Up Facilities. Routine environmental clean-up facilities (e.g., clinic and bathrooms) do not require modification unless contaminated with blood or body fluids. If so, the area should be decontaminated using the procedure outlined. Regular cleaning of non-contaminated surfaces, such as toilet seats and table tops, can be done with the standard cleaning solutions or the 1:10 bleach solution described above. Regular cleaning of obvious soil is more effective than extraordinary attempts to disinfect or sterilize surfaces.

Cleaning Tools. Rooms and dustpans must be rinsed in disinfectant. Mops must be soaked in disinfectant, washed, and thoroughly rinsed. The disinfectant solution should be disposed of promptly down the drain.

Laundry. Whenever possible, disposable barriers (e.g., disposable gloves and gowns) should be used if contamination with blood or body fluids is possible. If sheets, towels, or clothing become soiled, they should not be handled more than necessary. Wash contaminated items with hot water and detergent for at least 25 minutes. Presoaking may be required for heavily soiled clothing. The most important factor in laundering clothing contaminated in the school setting is elimination of potentially infectious agents by soap and hot water.

Soiled student clothing should be rinsed using gloves, placed in a plastic bag, and sent home with appropriate washing instructions for the parents.

Accidental Exposure

Accidental exposure to blood, body products, or body fluids places the exposed individual at risk of infection. The risk varies depending on the type of body fluid (e.g., blood vs. respiratory vs. feces), the type of infection (e.g., salmonellae vs. haemophilus influenzae virus vs. HIV), and the integrity of the skin that is contaminated.

Procedure.

1) Always wash the contaminated area **immediately** with soap and water.

2) If the mucous membranes (i.e., eye or mouth) are contaminated by a splash of potentially infectious material or contamination of broken skin occurs, irrigate or wash area thoroughly.

3) If a cut or needle injury occurs, wash the skin thoroughly with soap and water.

In instances where broken skin or mucous membranes, or a needle puncture occur, the caregiver should document the incident. The student's parent or guardian should also be notified. The person who was exposed to the infection should contact his/her health care provider for further care as outlined in the recommendations by the Centers for Disease Control and Prevention (CDC).

Pregnant Women

Pregnant women are at no higher risk for infection than other caregivers, as long as appropriate precautions are observed. There is, however, the possibility of in utero transmission of viral infections, such as cytomegalovirus (CMV), HIV, or HBV to unborn children.

Guidelines for Exposure Policy Development

As of 1992, all school divisions, should have an exposure policy as mandated in the Virginia Department of Labor and Industry's *Occupational Exposure to Bloodborne Pathogens; Final Rule (1992).* For assistance concerning an exposure policy, contact the Virginia Department of Labor and Industry's Regional Office.

Department of Labor and Industry
Powers-Taylor Building
13 South Thirteenth Street
Richmond, VA 23219
Telephone: (804) 371-2327
Fax: (804) 371-2324
TDD: (804) 786-2376
E-mail: jap@doli.state.va.us

Resources

Virginia Department of Health and Virginia Department of Education. (1992). Universal Precautions for Handling Blood Body Fluids in School. In *Virginia School Health Guidelines* (pp. 195-202).

Bradley, B. (1994). *Occupational Exposure to Bloodborne Pathogens, Implementing OSHA Standards in the School Setting.* Scarborough, Maine: National Association of School Nurses, Inc.

COMMONWEALTH of VIRGINIA

Department of Health
P O BOX 2448
RICHMOND, VA 23218

E. Anne Peterson, MD, MPH
State Health Commissioner

TDD 1-800-828-1120

MEMORANDUM

Date: August 9, 1999

To: District Directors

From: Casey W. Riley, Director
Division of HIV/STD

Re: Division of HIV/STD Training

I am very pleased to announce the availability of several new HIV/STD training initiatives that complement the trainings the Division of HIV/STD currently delivers. The Division, in conjunction with the five Regional HIV/AIDS Resource and Consultation Centers (RARCC), provides training opportunities that promote effective disease control and prevention. Within the attached brochure, you will find a brief synopsis of each of the programs that are being offered. These courses are intended to enhance the working knowledge of the health care providers in, but not exclusive to, HIV/STD intervention. By offering a diverse selection of learning experiences, designed to promote effective applications of disease intervention techniques and processes, we hope to support you in your effort to intervene in the spread of HIV/STDs.

Should you or any of your staff be interested in additional information regarding any of the courses offered, please contact Chip Payette, Training Coordinator, Division of HIV/STD, at (804) 371-2911.

/agc
Enclosure
c: Jeff Lake
Chip Payette

September 22, 1997

MEMORANDUM

To: District Directors

From: John V. Rullan, M.D., M.P.H.
Office of Epidemiology

Subject: VDH Post-exposure prophylaxis guidelines to Occupational HIV exposure

Included are the guidelines re: post-exposure prophylaxis (PEP) to HIV exposure in VDH employees. These guidelines follow the CDC's MMWR article "Update: Provisional Public Health Service Recommendations For Chemoprophylaxis After Occupational Exposure to HIV" published June 7, 1996.

If an employee is identified as eligible for PEP and decides to accept PEP, the Health District will provide the initial treatment of the employee, including the initial supply of the PEP medication. As soon as possible, the employee should be referred to his Primary Care Physician for subsequent follow-up and treatment (see Table 3, page 6). Please be aware that each district will be responsible for the cost of the initial supply of medications, as well as any costs such as prescription and laboratory co-pays not covered by the exposed employee's health insurance carrier.

The Workmen's Compensation policy does not include prophylactic treatment. The occupational exposure is to be documented so that if HIV infection does occur prospectively and no other risk factor can be attributed, then the employee could be eligible for the compensation benefit.

Clinical evaluation should include a baseline medical history and physical examination as soon as possible after the exposure. The employee should be advised to report and seek medical evaluation for any acute febrile illness that occurs within 12 weeks after the exposure (NOTE: this is especially important now that recent data presented by Markovitz et al.[4] have shown that early aggressive treatment with zidovudine, lamivudine and ritanovir has potential for significantly reducing the circulating virus to undetectable levels). Such an illness- particularly one characterized by fever, rash, pharyngitis, or lymphadenopathy- may be indicative of recent HIV infection. During the first 6-12 weeks following the exposure, when most infected persons are expected to seroconvert, the exposed employee should be recommended to follow U.S. Public Health Service (PHS) recommendations for preventing transmission of HIV.[5] Appropriate precautions should be taken to prevent sexual partners from coming into contact with the blood, semen, or vaginal secretions of the employee. Abstention from sexual activity with another person is an option for eliminating sexually transmitted HIV disease, while use of condoms is a option for reducing the transmission of HIV. The employee should not share toothbrushes, razors or other items that could be contaminated with blood. The employee should also refrain from donating blood, plasma, body organs, other tissue, or semen during the follow up period.

After appropriate counseling and informed consent, serological evaluation should be performed. Blood for a baseline HIV test should be obtained from the exposed employee as soon as possible following the exposure. For those employees with a negative baseline test, repeat HIV testing should be done at 6 weeks, 12 weeks, and 6 months following exposure.[1]

The decision to start post-exposure prophylaxis should be based on the risk assessment of the attributes of exposure and the attributes of the source patient (see Table 1). Exposed individuals should be informed that (a) the knowledge about the efficacy and toxicity of post-exposure prophylaxis is limited; (b) for agents other than zidovudine, data are limited regarding toxicity in persons without HIV infection or who are pregnant; and © any or all drugs for post-exposure prophylaxis may be declined by the exposed employee. If a decision is made to implement post-exposure prophylaxis, it should be initiated within 1-2 hours following exposure (the interval after which there is no benefit from post- exposure prophylaxis in humans is undefined). The recommended duration of post-exposure prophylaxis is 4 weeks.

Exposed health-care workers who express interest in prophylaxis but cannot make a rational decision often benefit from starting treatment and then reconsidering their options once they feel more objective or updated information becomes available. Special emphasis should be made to not delay the prophylaxis decision until better information becomes available or a clinic appointment can be arranged.

For exposed employees receiving post-exposure prophylaxis, drug toxicity monitoring is necessary. The employee should be questioned about and educated to report toxicities known to be associated with the medications used. Zidovudine (ZDV) used for post-exposure prophylaxis is generally well tolerated but can be associated with gastrointestinal symptoms, fatigue and headache.

In HIV infected adults, lamivudine (3TC) can cause gastrointestinal symptoms and in rare instances, pancreatitis. Indinavir (IDV) toxicity includes gastrointestinal symptoms, and usually after prolonged use, mild hyperbilirubinemia (10%) and kidney stones (4%); the latter may be limited by drinking 48 oz (1.5L) of fluid per 24- hour period, while the drug is taken. During the first 4 weeks of indinavir therapy, the reported incidence of kidney stones has only been 0.8%. The concurrent use of indinavir and certain other drugs, including some nonsedating antihistamines, is contraindicated.

Laboratory monitoring of drug toxicity consists of a baseline complete blood count, and renal and hepatic chemical function tests. These should be repeated two weeks after starting post-exposure prophylaxis. If subjective or objective toxicity is noted, dose reduction or drug substitution should be considered with expert consultation. (See Table 2)

TABLE 1. Provisional Public Health Service recommendations for chemoprophylaxis after occupational exposure to HIV, by type of exposure and source material — 1996

Type of exposure	Source material*	Antiretroviral prophylaxis†	Antiretroviral regimen§
Percutaneous	Blood¶		
	Highest risk	Recommend	ZDV plus 3TC plus IDV
	Increased risk	Recommend	ZDV plus 3TC, ± IDV**
	No increased risk	Offer	ZDV plus 3TC
	Fluid containing visible blood, other potentially infectious fluid††, or tissue	Offer	ZDV plus 3TC
	Other body fluid (e.g., urine)	Not offer	
Mucous membrane	Blood	Offer	ZDV plus 3TC, ± IDV**
	Fluid containing visible blood, other potentially infectious fluid††, or tissue	Offer	ZDV, ± 3TC
	Other body fluid (e.g., urine)	Not offer	
Skin, increased risk§§	Blood	Offer	ZDV plus 3TC, ± IDV**
	Fluid containing visible blood, other potentially infectious fluid††, or tissue	Offer	ZDV, ± 3TC
	Other body fluid (e.g., urine)	Not offer	

*Any exposure to concentrated HIV (e.g., in a research laboratory or production facility) is treated as percutaneous exposure to blood with highest risk.

†*Recommend*—Postexposure prophylaxis (PEP) should be recommended to the exposed worker with counseling (see text). *Offer*—PEP should be offered to the exposed worker with counseling (see text). *Not offer*—PEP should not be offered because these are not occupational exposures to HIV (*1*).

§Regimens: zidovudine (ZDV), 200 mg three times a day; lamivudine (3TC), 150 mg two times a day; indinavir (IDV), 800 mg three times a day (if IDV is not available, saquinavir may be used, 600 mg three times a day). Prophylaxis is given for 4 weeks. For full prescribing information, see package inserts.

¶*Highest risk*—BOTH larger volume of blood (e.g., deep injury with large diameter hollow needle previously in source patient's vein or artery, especially involving an injection of source-patient's blood) AND blood containing a high titer of HIV (e.g., source with acute retroviral illness or end-stage AIDS; viral load measurement may be considered, but its use in relation to PEP has not been evaluated). *Increased risk*—EITHER exposure to larger volume of blood OR blood with a high titer of HIV. *No increased risk*—NEITHER exposure to larger volume of blood NOR blood with a high titer of HIV (e.g., solid suture needle injury from source patient with asymptomatic HIV infection).

**Possible toxicity of additional drug may not be warranted (see text).

††Includes semen; vaginal secretions; cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids.

§§For skin, risk is increased for exposures involving a high titer of HIV, prolonged contact, an extensive area, or an area in which skin integrity is visibly compromised. For skin exposures without increased risk, the risk for drug toxicity outweighs the benefit of PEP.

Table 2 - Follow-up schedule for occupational exposure to HIV infection

Visit 1 (day 1)	Risk assessment, baseline HIV test, post-exposure prophylaxis decision. For those receiving post-exposure prophylaxis, baseline CBC, renal and hepatic function tests
Visit 2 (day 14)	For those receiving post-exposure prophylaxis, CBC, renal and hepatic function tests
Visit 3 (day 28)	Post-exposure prophylaxis therapy completed
Visit 4 (day 42)	HIV test (if previous test negative)
Visit 5 (day 84)	HIV test (if previous test negative)
Visit 6 (day 180)	HIV test (if previous test negative)

Table 3 - Administrative follow-up for HIV Occupational Exposure

1) "Person in charge"(PIC) fills out questionnaire to document exposure and source information.

2) PIC reviews prophylaxis information and lab follow up schedule

3) Employee accepts/declines prophylaxis

4) PIC arranges for Health District to dispense medication (initial supply) to employee

5) Employee referred to Primary Care Physician (PCP) for emergency follow-up and subsequent medication supply and lab work-up

6) PIC enrolls employee in CDC registry (888)PEP-4HIV (voluntary)

7) PIC closes employee record if no seroconversion has occurred after the 6 month visit. If seroconversion has occurred, PIC refers employee to the workman's compensation unit.

References

1. Update:provisional Public Health Service recommendations for chemoprophylaxis after occupational exposure to HIV. MMWR Morb Mortal Wkly Rep. 1996; 45:468-80.

2. Gerberding JL. Prophylaxis for Occupational Exposure to HIV. Ann Intern Med. 1996; 125:497-501.

3. Case-control study of HIV seroconversion in health-care workers after percutaneous exposures to HIV-infected blood-France, United Kingdom, and United States, January 1988-August 1994. MMWR Morb Mortal Wkly Rep. 1995; 44:929-33.

4. Markowitz, M. Treatment intervention in newly infected patients. Presented at XI International Conference on AIDS, Vancouver 10 July 1996.

5. Prevention of Acquired Immune Deficiency Syndrome (AIDS): Report of Inter-Agency Recommendations. MMWR Morb Mortal Wkly Rep. 1983;32:101-03.

Guidelines for Children in Schools and Daycare Centers

Section 22.1-272 of the Code of Virginia entrusts to local school officials the responsibility for admitting children with HIV/AIDS infection to school. In 1985 the Attorney General stated that school officials responsible for making these determinations should consider qualified medical advice and information furnished from sources such as the child's physician, public health officials and school nurses. The district director should review the information provided, preferably in conjunction with the child's private physician, bearing in mind that as a general rule school attendance is encouraged. We suggest a written response to the superintendent along the following lines:

Personal and Confidential

Date

Dear Superintendent:

I have considered your request pertaining to the advisability of allowing John Doe, who has HIV infection, to attend school.

The child's physician and I have considered your request in accordance with the recommendations of the Board of Health on this subject, and the interpretation of section 22.1-272 of the Code of Virginia by the Attorney General. After a very careful review, it is our opinion that there is no medical reason for excluding him from school or it is our opinion that he should not be allowed to attend school at present. Another review should be conducted in x months.

We recommend the same format when assistance is requested about admitting HIV-infected children to day care centers.

District directors should be aware that on January 13, 1986, the Attorney General ruled that Section 32.1-78 of the Code of Virginia requires the Commissioner to report to the Superintendent of Public Instruction or the appropriate school division the names of, and pertinent information about, students who have AIDS. If the Commissioner determines that those students have health problems associated with the disease might affect their career in school, he may require that they receive special education.

COMMONWEALTH of VIRGINIA

Department of Health
P O BOX 2448
RICHMOND, VA 23218

ANDOLPH L. GORDON, M.D., M.P.H.
OMMISSIONER

TDD 1-800-828-1120

February 26, 1997

MEMORANDUM

TO: District Health Directors

FROM: Casey W. Riley, Director
Division of STD/AIDS

SUBJECT: STD/HIV Interview Time Periods

In May 1996, President Clinton signed Public Law 104-146, an amendment to the Ryan White CARE Act. The law includes a requirement that states take administrative or legislative action starting April 1, 1997, to ensure a good faith effort is made to notify a spouse of a known HIV-infected patient of potential exposure to HIV and to encourage such spouses to seek HIV testing.

HIV partner notification has been in place since the 1980s. While the new law requires additional notification for some individuals, it does not significantly increase workload on staff. ***Starting April 1, 1997, the previous ten years of an HIV-infected patient's marital history should be reviewed and all spouses at risk for infection should be appropriately notified. Recommendations regarding the STD/HIV partner notification process can be found in the "STD Epidemiology" section of the STD Manual. There is no requirement to lengthen the interview time period to ten years for the spouses of those HIV-infected patients reported to VDH prior to April 1, 1997.***

Summary of Partner Notification Interview Procedures - Effective April 1, 1997

- Marital status should be obtained and documented on a field record for all HIV-infected patients.

- The interview period for HIV-infected patients, who are not separated or divorced and have never been separated or divorced, is one year from the date of the patient's positive HIV test. Spouses exposed to HIV are notified.

- The partner notification interview period for separated and divorced HIV-infected patients is extended to identify marriage partners in the past ten years.

- There is no need to go back ten years for HIV-infected separated or divorced patients with a known infectious period (known negative HIV test date). Spousal notification should encompass the six months prior to the negative test date.

If you have any questions, please call me at (804) 786-6267.

/pkt
c: Jeff Lake
Dr. Grayson Miller, Jr.

Division of HIV/STD

Statistics and Data Management Program

RULE OF THREE

In order to protect the confidentiality of persons reported with communicable diseases in Virginia, the Division of HIV/STD follows the "Rule of Three" as recommended by the Centers for Disease Control (CDC) in Atlanta.[1] Basically, the Rule of Three states that no data cell for a particular demographic characteristic may be revealed to the general public if that cell contains less than three. Likewise, if the contents of a suppressed cell in a table could be determined by simple addition or subtraction of the non-suppressed rows or columns in a table, then additional rows or columns would also need to be suppressed.

An example of how this may be accomplished would be the following:

A breakdown by race reveals the following:

White	**100**
Black	**50**
Hispanic	**1**
Asian	**1**
Other	**2**

In order to prevent inadvertent disclosure of the individuals in the Hispanic or Asian categories, the information would be released to the news media as:

White	**100**
Black	**50**
Other	**4**

---

1 CDC Staff Manual on Confidentiality: U.S. Department of Health and Human Service; Centers for Disease Control; Atlanta, Georgia 30333; February 1984.

In providing the attached information on disease statistics, the Division asks your cooperation in following the Rule of Three so as to assure our citizens an appropriate level of protection from undue disclosure. Should you have questions regarding the Rule of Three or its implementation, please call the Statistics and Data Management Program at 804/225-3750.

VIRGINIA DEPARTMENT OF HEALTH
Revised Eligibility Guidelines
Effective July 1, 1994

ELIGIBILITY PROCESS

The eligibility process starts when the original CHS-1 is completed.

If a valid proof-of-income is not presented at the time the original CHS-1 is completed, the applicant will receive no discount for the services he/she received unless he/she provides proof of income within 10 working days or the next visit, whichever is sooner. If a valid proof of income is provided within 10 working days, charges will be discounted back to the date of completion of the original CHS-1.

NOTE: WIC, CDS, and CSS require proof of income before certification. As necessary, CSS and CDS also require proof of the applicant having applied to medicaid and SSI.

If the applicant does not provide proof of income within 10 working days, no discounts will be given for prior services. If an applicant provides the information after 10 working days and is determined to be an "A", the past charges may be discounted at the director's discretion.

NOTE: When an applicant receives a medicaid card after the eligibility date, staff are to bill medicaid for all possible visits. Any credits to the account shall be refunded to the applicant.

When the eligibility is due, if the applicant does not have a valid proof of income, he/she will be charged full fee. These charges may be reduced if the proof of income is brought in according to the above guidelines.

Eligibilities must be completed every 12 months or as required by other programs, (WIC) or

Eligibilities may be completed when:

1. Income scales are revised or,
2. When the health department has reason to believe the patient's eligibility status or family composition has changed or,
3. when a patient requests a waiver.

Automatic Eligibility

Once it is established that a person is in one of the categories listed below, he/she is eligible for services as an indigent patient. Once the proof of income is provided, no other financial information is necessary; however, it is important to get all insurance information so that services can be billed.

Proof of Income for Automatic Eligibility:

1. General Relief: Check stub or letter
2. Medicaid: current card or notice of eligibility, listed on the medicaid printout, or documented call to the REVS. A copy of the card shall be made at the time of eligibility or document information from the card.
   Babies born to women on medicaid do not receive automatic eligibility.
   EXCEPTIONS: Staff need to be aware that while the applicant may be covered by medicaid, the remaining family members do not receive automatic eligibility status.
3. School lunch (for school dental services only) Verification

from school required that the child is eligible for the free lunch program.

4. Services to Minors

Unmarried minors seeking family planning or maternity services are automatically eligible for services at full discount. All others will have an eligibility completed for family planning or maternity services.

Note: ~~Full discounts do not apply to pregnancy tests~~

For minors, pregnancy tests are also considered a fully discounted service. For all others, pregnancy tests are chargeable except when ordered as part of a family planning visit. Pregnancy tests are subject to the sliding fee scale.

5. Do Not Contact (DNC)

A DNC patient is a patient receiving family planning or maternity services who requests that no bills or notices be sent to her home. No patient is considered automatically DNC, but all unmarried minors seeking these services should be asked if they wish to be a DNC patient. While unmarried minors seeking DNC status are automatically eligible for full discount, others seeking DNC status must go through the complete eligibility process.

Prior to services being rendered, an explanation of the charges, applicable discounts, and expected payment shall be provided to the applicant.

Note: Patients who are not unmarried minors, but who are also DNC shall not be sent a bill, shall not be referred for collection or Debt Set-Off and shall not be denied service.

Definition of Family

1. The family unit may consist of:

   A. Husband and wife and/or their minor dependents.

   B. A single individual and his/her minor dependents.

   C. An individual with no minor dependents.

   Notes: (1) A woman who is pregnant should be counted as a multiple beneficiary when the pregnancy has been verified by a physician or a nurse practitioner working under the supervision of a physician.

2. A minor is a person, who is less than 18 years of age whose parents(s) are responsible for his/her care. A minor is considered a separate family unit when married or not living with any relatives or deemed an adult for sexually transmitted disease or any contagious or infectious disease, birth control, pregnancy or family planning except for the purpose of sexual sterilization.

3. Where and when individuals other than spouses and their minors reside together, each shall be considered a separate family unit and shall not be a dependent of another family unit. Proof of dependency from the Internal Revenue Service is not considered a basis for determination of family unit. Examples of separate family units:

A. Elderly person(s) who live in the home of their children or a relative.

B. A mother (18 and over) and her child who live with her parents or a relative.

C. The child of an unemancipated minor who lives with her mother and grandparent/s.

D. A minor placed in a foster care home.

E. A minor living with a legal guardian who does not have financial responsibility.

F. Unrelated individuals living together or as cohabitating partners.

4. A husband and wife who are separated shall be considered separate family units when they are not living together and are not dependent on each other for support.

5. A Medicaid recipient who is a minor receiving SSI or ADC payments shall be a separate family unit. A Medicaid recipient without SSI or ADC shall be part of a basic family unit as described in paragraph #1. The child who is considered a separate family unit is not part of the larger family unit when calculating their income.

6. For family planning services, individuals requesting DNC may be a separate family unit and would require an eligibility determination.

7. For joint custody, both parents must designate a head of family or the parent presenting for services will be considered the head of the family. The family unit will be

that of the designated head and his/her family unit plus the child in joint custody.

8. The family unit for a parent paying child support excludes the minors for whom the child support payments are intended. The family unit which receives child support payments shall include the minors for whom the child support payments are intended.

Proof of Income

In the majority of cases, income can be verified by determining the family's money wages and salaries before any deductions (gross income). Wage and salary verification must be determined for all adults in the family. (Earned income of minor children are excluded.) If there is any question about the authenticity of the pay stub (no name or social security number), staff may require a statement on company letterhead.

The following documentation can be used as proof of income.

1. Pay stub with year-to-date total

   If the calendar year-to-date total is on the stub; and, the applicant was employed by the same employer since January 1st; and, the year-to-date income covers three or more months of continuous employment, then, only one pay stub is needed to use the CSS calendar to compute annual income.

2. If year-to-date totals are not available, then check stubs for the past three consecutive pay periods are recommended.

3. For people who have worked on their current job for less than three months, use a current check stub to determine a regular

amount of pay (hourly, weekly, monthly, etc.) and calculate income as if the person were working the entire year.

4. Persons on strike are to be treated as a person who has changed jobs. (Refer to #3)

5. Persons who might be off the payroll for sickness or some other reason should have their family income figured based on the income at the time of application. When they return to work, a new eligibility must be completed.

6. In some cases it may be inappropriate to use check stubs as verification (seasonal workers, for example.) In those cases, a W-2 from the previous year should be requested.

7. When making the initial eligibility application, overtime should be considered part of the gross earnings. If the interviewer notes a large amount of overtime as part of the gross income, the applicant should be asked if the overtime is a regular occurrence. If it is not regular, the applicant can be asked to bring back three future consecutive pay stubs. The eligibility would be recalculated based on the gross pay of those stubs. All pay stubs must note the pay period for which the stated income was earned.

8. If no wage or salary statements are available, then the following verifications are:

   A. The most recent annual tax return should be requested. The gross income is calculated by adding the total from line 23 of the 1040 form. (Line 14 on the 1040A form) If the applicant is self-employed, income is figured as

above plus any depreciation shown on line 13 of Schedule C. If income includes or is totally from farm income, income must include any depreciation taken on Schedule F.

B. If no tax return is available, one of the following will be considered as adequate proof of income:

(1) Statement from employer - Required to be on company letterhead, dated, signed, and have sufficient information to allow calculation of current gross pay. In exceptional cases, oral verification from the employer can be used as proof of income.

(2) Some people who are self-employed may only have ledgers that they keep about their business' revenues and expenses. When these ledgers are brought in as proof-of-income one of two approaches may be used:

(a) If possible, determine what they paid themselves and their family members.

(b) If (a) is not possible then determine their revenues and subtract out all expenses except depreciation. This remaining total will be their gross income.

(3) In certain cases a self-declaration of income is acceptable. Examples are those who are homeless and day workers. Tips for those earning them could be reported in this manner. The applicant should be

asked to write out a statement such as "My estimated yearly income is_____." The statement should be signed and dated.

(a) Migrant and seasonal workers may also self-declare their income.

(4) A signed letter from the Department of Social Services stating the income used by Social Services to determine eligibility.

9. Social Security and railroad retirement

Any one of the sources listed below may be used as verification:

A. Documents stating the amount of the entitlement

B. Official award letter or notice

C. Benefit payment check or proof of direct deposit amount. Deductions for Medicare Part B are to be added to this amount to compute total monthly income.

D. If none of the above sources are available, other sources, such as an adult child, may be contacted, but only with written consent of the applicant.

10. Persons Receiving Unemployment Benefits

The only allowable verification is a statement from the Virginia Employment Commission stating the amount of benefits and the weeks remaining. The person receiving unemployment benefits should be treated as a person who has changed jobs.

11. Worker's Compensation/Veteran's Benefits

A. Documents stating the amount of the payment

B. Benefit payment check or proof of direct deposit amount

12. Applicant states he/she has no income

All applicants claiming no income should be closely questioned about how they are supporting themselves. The interviewer should also make certain that they are identifying the correct family unit.

A. If the applicant states that he/she has no income, the following documentation may be used:

(1) Statement from Virginia Employment Commission denying unemployment compensation

(2) Termination notice from previous employer

(3) Layoff notice from previous employer

B. If the person claims they have no income, but are receiving support from another person who is not a member of the family, then the applicant must provide a signed statement (food and shelter) from the person providing the support. (See sample statement on page ___). This statement should provide the estimated length of support. It can be given to the applicant or mailed directly to the person who may be providing the support.

C. An applicant who appears to be homeless and have no regular source of income or way of verifying income can self-declare what their income is with no additional verification needed.

13. Alimony/Child Support

This can be verified by the applicant providing any legal

document (divorce papers, letter of support, judgement, custody papers, copies of checks) that state the amount and frequency of payment. A written declaration of child support is also acceptable.

A copy of the ex-spouse's tax return showing alimony payments would also be acceptable.

14. Military Pay

The most recent member's copy of the leave and earnings statement (LES) form must be used to determine income. Income includes monthly base pay, hazardous pay and all other cash benefits.

15. Training Stipends

These are funds paid to a person while in training. This includes Job Corps, or payment of part or all of salary while in school. Verification can be made by check stub or by a letter of award that the student receives.

16. Children in Foster Care

Children in Foster Care are considered separate families. Any payment from the Department of Social Services for their care should be considered part of the child's income and not part of the foster parents income.

17. Family with Income only from Checking/Savings Accounts

Sometimes an applicant may claim no income, but have a sizeable amount of money in a checking or savings account. (Sizeable is a combined amount of more than $10,000). When this occurs, the interviewer needs to determine if the amount

is earned income. (Earned income is that income that the family was able to save when a family member was employed.)

A. If the amount is from earned income, only the interest from those accounts should be counted as income.

B. If the amount is not earned income (examples: money brought into the country by legal aliens, past judgement awards), then the entire amount in the accounts is to be considered as income. It would also be permissible to use the amount that was withdrawn from the accounts in one year's time, but the applicant must have bank records to prove the difference.

18. Other types of benefits

A. Private pensions\Military retirement

The same type verifications are acceptable as for the recipient of social security. As for most categories, tax records are acceptable.

B. Regular Insurance or Annuity Payment - See 9A above

C. Dividends and Interest - Acceptable types of verification are bank statements (quarterly or semi-annual give a better picture of what annualized amount would be), past year's 1099's or a copy of the applicants past year 1040, line. For the self-employed and in other cases where the total income is used (line 23 of the 1040) it is not necessary to add in dividends and interest and other sources of income.

D. Net Rental Income - Review Tax Information. Generally

included in Schedule C or E. Will show on line 18 of 1040 which is part of line 23.

E. Net Royalties - Review tax information. Generally included in Schedule C or E and will show up as part of line 23 on the 1040.

F. Periodic Receipts from Estates or Trusts - Several possible sources of verification are acceptable. These include copies of legal documents, tax records, 1099's and bank records.

G. Lump Sum Settlements - These include inheritances, one time insurance payments, and injury compensation awards. Verification can be made by checking the award letter or copying the check. In some cases it may be necessary to check with the court.

H. Net Gambling Winnings - This is shown on line 22 of the 1040 tax form and is, therefore, part of the line 23 total.

I. Lottery Winnings - Although the recipient should be asked about their income related to lottery winnings, verification is not required unless the applicant is known to have won a large prize or states they have. Large is defined as $1,000 or more. Lottery winnings would be shown on the federal tax form.

19. Gross income does not include:

A. Food stamps

B. WIC checks

C. Fuel assistance payments

D. Housing assistance - This exclusion is limited to non-military government-provided subsidies

E. Money borrowed

F. Tax Refunds

G. Gifts

H. Withdrawal of bank accounts from earned income - Interest is to be included as income

I. Earnings of minor children

J. Money received from the sale of property

K. General relief frsom the Department of Social Services

L. College or university scholarships, grants fellowships and assistantships

Residence

Non-mandated services may be limited to residents of Virginia. Proof of residence may be a Virginia driver's license, rent/mortgage payments, utility payments, voter registration, or any other document that establishes Virginia residency. Mandated services are defined as those four services listed in the non-chargeable section of these guidelines.

The district director or program director can limit the provision of certain health services based on an assessment of public need and available department resources.

The district director or program director may establish policies to limit the provision of certain health services provided by the department based on legal residence and visa status except

where federal funds are appropriated for the service.

Non-Chargeable Services

The following services are to be provided at no charge.

1. Those immunizations for children as required by §32.1-46 of the Code of Virginia, and of persons up to the age of 21 when the person lacks evidence of complete and appropriate immunizations for the diseases covered by that section of the Code.

   Vaccines covered by the Code are diphtheria, tetanus, whooping cough, (DPT), poliomyelitis, haemophilus influenza type B, (HIB), measles, Germanic measles and mumps (MMR). Adequate vaccination for the above shall be free.

   Tetanus/diphtheria for adults is also free, but an administration charge may be charged.

   All other routine vaccinations provided by the department shall be charged to the patient.

2. Examination and testing of persons suspected of having or known to have tuberculosis as required by §32.1-50 of the Code of Virginia.

   Initial skin tests and the examination to rule out tuberculosis is free for contacts ~~of infectious tuberculosis patients.~~ <u>to persons with suspected or confirmed TB disease.</u> The follow-up examination for all other significant reactors is also free. Examination includes a chest x-ray and its interpretation, a physical examination, and initial recommended lab work.

Whenever the Bureau of TB Control contracts a vendor for x-ray or lab services, the patient is not to be charged for those services.

Physician recommended ongoing care may be charged to the patient. If charged, the sliding fee schedule must be used. This includes clinical care, ancillary services, and drugs. Patients with suspected or diagnosed Tuberculosis should not be denied the above services due to non-payment.

3. Examination, testing and treatment of persons for venereal sexually transmitted diseases as required by §32,1-57 of the Code of Virginia.

Persons whose diagnosis, either suspected or confirmed, is syphilis, gonorrhea, chancroid, granuloma, lymphogranuloma, or venereum~~.~~ ~~HIV or chlamydia infection~~ shall have their examination, testing, and treatment provided free of charge~~,~~ ~~if available~~. Persons whose diagnosis, either suspected or confirmed, is HIV or chlamydia shall have their examination provided free of charge.

~~If the diagnosis is not one of those listed above,~~ If funding has not been specifically provided, diagnostic tests and medications for HIV, Chlamydia and other nonreportable sexually transmitted diseases can be charged to the patient. (See the section on chargeable services for specific information on how to charge.)

4. Anonymous testing for human immunodeficiency virus as required by 32.1-55.1 of the Code of Virginia.Testing for human

immunodeficiency virus (HIV) is a free service. Districts are discouraged from charging for a venipuncture and handling.

Flat Rate Charge

Flat rate charges are made for services that have been determined by the department to be not essential for public health protection. Charges are not subject to the sliding fee schedule.

The following services have been approved by the Commissioner to be provided on a flat fee basis.

A. Cholesterol tests when provided on a mass screening basis

B. Flu shots and pneumovax

C. Overseas travel immunizations. An administration fee may also be charged on a flat fee basis

D. PPD testing when performed as a screening examination

E. Venipuncture outside lab and handling fee when provided to patients on a walk-in basis and not part of a regular routine clinic service.

F. Chest x-rays for routine tuberculosis related screenings

G. Activities of daily living is available for non-medicaid patients. Personal care is available for only patients with medicaid. The co-insurance for persons receiving personal care will be treated as a flat rate charge.

H. Adult dental patients will be charged a flat fee of $10.00. In addition to this fee, any chargeable dental services will be provided on a sliding scale basis.

I. Other services may be provided on a flat fee basis if there is a written agreement between the district\program

and the contracting agency. Examples are: Rabies and Hepatitis for animal control workers and Tine tests for teachers or restaurant workers.

Services Provided on a Sliding Fee Basis

Most services provided by the department are provided on a sliding fee basis. At the eligibility determination a discount percentage based on the applicant's income and family size is calculated. This discount is subtracted from the full charges and the applicant is responsible for paying the remaining amount.

Services that are not subject to the sliding fee scale are listed throughout this section and the subsequent sections concerning charges.

All services are provided on a fee for service basis. Charges are based on medicaid payment levels. For services that no medicaid payment level exists, the charge will be based on the cost of providing the service.

Maternity

Health departments provide maternity services as prescribed by the Maternal Health guidelines. It is the department's policy to charge maternity patients on a per visit basis for visits made due to pregnancy. (Use a "Z" code for medicaid patients and patients with no insurance.) There is no limit on the number of billable visits. Use an evaluation/management (E/M code for women who will have their care billed to private insurance. When care is provided for conditions not related to pregnancy, the visit should be billed using an evaluation/management code. Whenever possible, a HCFA-

1500 form should be used to bill insurance companies including medicaid.

Babycare

Babycare is maternal and infant care coordination (MICC) plus nutrition counseling, homemaker services and educational classes. Using medicaid guidelines, it is available on a sliding fee basis to all eligible patients.

Risk screens (DMAS-17 form) are to be completed on all maternity patients and infants with medicaid cards. Additional risk screening forms can be submitted as the status changes.

MICC is billed each month based on days in the program. Homemaker services are billed on hours of service provided. Billing for educational classes is done per class attended while nutrition education is billed per visit.

Medallion

Medallion is a managed care program sponsored by medicaid. If a district is a Medallion provider, they should provide care to their panel of medicaid enrollees as prescribed in their provider agreement.

Districts who are not providers can provide maternity, EPSDT, family planning,dental, and BABYCARE services to any medicaid recipient. It is recommended that the patient's primary care provider be contacted and authorization received before providing EPSDT services to a child covered by the Medallion program.

In order for medicaid to pay for any follow-up or acute care, authorization must be received from the patient's primary care

provider and noted on the HCFA-1500.

Pediatric/Well Baby

Health Departments provide pediatric/well baby services using the guidelines prescribed by the Child Health Manual. If the patient is a medicaid recipient and is eligible for a EPSDT, a preventive management CPT code should be used to bill for the services. (A preventive management code should be used for non-medicaid patients receiving well child care.) Any visits made for pediatric care between the periodicity schedule will be billed using an evaluation/management code.

Family Planning

Health Departments provide family planning services as prescribed by the family planning guidelines. The patient should be charged for either initial/annual or a follow-up visit. For DNC patients, third party payors will not be billed. (This includes medicaid.)

If the patient does not meet the family planning service criteria, this individual should be referred to another type of clinic for check-ups and pap smears.

Gynecology

Gynecology patients are charged for each clinic visit using EM codes.

Colposcopy Services

A patient receiving a colposcopy (with or without a biopsy) should be charged according to the charge schedule. If cryosurgery is performed, it should be billed separately at the charge listed

in the department's charge schedule.

General Medical Services

General medical services include health maintenance, care for chronic conditions, and acute care that the district may provide. All services provided must be provided using evaluation/management or preventive medicine codes on a sliding fee basis.

LAB

Lab tests should be billed accordingly to the charge schedule. For any test sent to outside reference labs, the district may choose to not offer a discount on those tests. All lab tests performed on-site may be provided on a sliding fee basis. No charge should be made for any lab tests for which the Bureau of Tuberculosis Control pays.

X-Ray

X-rays provided by the district, not as part of routine TB screenings, may be provided on a sliding fee basis. If contracted to outside vendors, they should be charged on a flat rate basis. No charge should be made for any X-rays that the Bureau of Tuberculosis Control pays for.

Dental

Charges for children will be based on medicaid payment rates and be provided on a sliding fee basis.

Charges for adults will be based on existing medicaid payment levels or on estimated costs when medicaid does not pay for a procedure. Except for the provision given in #8 of "Flat Fee Services", professional fees shall be provided on a sliding fee

basis. The patient will pay dental lab fees on a flat rate basis.

Pharmacy

A. Districts without Pharmacies

For any drug (both over-the-counter and prescription) given to a patient, the patient may pay either based on the cost of the other drug with no discount or on a sliding fee basis. Districts may choose which drugs are subject to the sliding fee scale.

B. Districts with Pharmacies

All drugs (both over-the-counter and prescription) may be provided ~~either~~ based on cost with no discount or on a sliding fee basis. Districts may choose which drugs are subject to the sliding fee scale. The prescription filling fee shall be subject to the sliding fee scale and can be charged for each prescription.

~~Note: For ancillary services the patient shall pay flat fee or sliding fee per district/program director's discretion which shall be based upon available resources.~~

Note: All TB drugs are subject to the sliding fee scale.

Home Health Services

Home health services are provided on a sliding fee basis. All efforts should be made to get the patient covered through the district's home health agency. When this is not possible, the visit to the home should be billed using an evaluation/management

code.

Child Development Services

Child Development Services are provided on a sliding fee basis.

Waivers

In instances when patients have unusually serious health problems or extraordinary financial hardships are demonstrated to exist, and there are no other avenues of care, the patient, guardian or other authorized person may request a waiver of charges for up to 90 calendar days. A waiver must be requested in writing to the program or district director.

The waiver provides a 100% discount for all services for up to 90 days. The start of the initial waiver period will be the day the waiver was received by the program or district. Balances due prior to a waiver may not be waived. When a waiver is requested, a new eligibility may be completed. If documentation is not available to support the request, it must be provided within 10 working days. If documentation is not provided within the allowable time, the start date of the waiver will be moved to the date the documentation was provided and the applicant will be responsible for any charges prior to the waiver effective date. Additional waivers may be granted but the applicant will have to reapply and provide documentation that the waiver is still needed.

An applicant will be determined to have unusually serious health problems when his/her medical bills are equal to or above 5% of the applicant family's gross income. Medical bills can include

office visits to medical facilities, medications, medical supplies, and equipment, dental services, laboratory and radiographic services, surgery, hospitalization, home health services, and outpatient facilities. In addition, the applicant may document travel expenses for transporting family members to medical appointments. Only mileage is allowed as an expense. It is to be calculated at $0.20 per mile. The CSS 402 form may be used to list medical expenses including reimbursement.

Once the medical expenses are totaled, take 5% of the family income. If that total is equal to or less than the medical expenses, then the applicant is eligible for a waiver due to unusually serious health problems.

Medical expenses used to determine a waiver in one period may be used in the waiver calculations for future periods. If the bills for the prior period are still outstanding staff should attempt to get the most current bills and not use the same ones over and over.

No waivers will be issued to persons believed to be eligible for Medicaid until the applicant has evidence that they have applied for Medicaid. Staff should review eligibility information already provided or do a new eligibility to determine if the person is eligible for Medicaid.

Extraordinary financial hardships would include such things as natural disasters, uninsured real or personal property damage or legal liability to another for the same, and obligatory and unavoidable expenditures for close relatives outside the family

unit.

By regulation, the Commissioner is designated to grant or deny waivers. However, he/she may delegate this authority to program ordistrict directors who may then delegate the authority to individuals under their supervision to grant or to deny the waiver. There should be written documentation at the program and district level as to who can grant waivers.

Appeal Process

If an applicant or patient client wishes to appeal a denial of services, a determined income level, or a waiver decision, the appeal process as outlined in the eligibility regulations (Part VII) must be followed.

It is suggested that the person appealing be given a copy of the appeal process that is in the regulations. This will let the person know what is expected of them and the various time lines that are required.

Fraud

In those cases where fraud is suspected, a new eligibility should be completed and the patient charged accordingly. Previous charges should not be readjusted.

Where there is proof of willful misrepresentation and other agencies may also be misled, those agencies should be notified that the person is defrauding them. Services may be discontinued to the affected person 30 days after notifying the person in writing, by certified mail, that saervices will be discontinued.

Example of Food and Shelter Letter

Dear_____

Your name has been given to the_____Health Department concerning the support you are providing for_____.

In order for us to complete his/her eligibility determination so that he/she may be seen in our clinic, we need you to complete the bottom of this letter and mail it back to us at the above address.

We appreciate your cooperation in this matter and wish to assure you that all information you give us will be kept confidential.

Sincerely.

_____

Director/Administrator

- -

I am providing _____with food and shelter as of _____. ~~I estimate this support has a value of $_____per month.~~ To my knowledge, he/she has no other means of support.

(name)

_____

(signature)

_____

(print name)

_____

(date)

VIRGINIA HIV/AIDS LEGISLATION BY YEAR

2001

SB 824 Amend the existing provision that allows the court to order HIV testing of persons charged with certain crimes to establish a procedure for a defendant whose competence is at issue. Prior to ordering testing a hearing must be held to determine that there is probable cause that the individual committed the crime.

HB 1823 Revises the authority of local governments to regulate tattoo parlors and body-piercing salons by adding specification of procedures for enforcement of compliance with disease control and disclosure requirements and requiring those localities that choose to regulate tattoo parlors and body-piercing salons to authorize unannounced inspections by appropriate personnel.

2000

HB 141 Creates the Class 6 felony of infected sexual battery when the offender has intimate sexual contact with someone knowing he is infected with HIV, Syphilis or Hepatitis B with the intent to transmit the infection to another person.

HB 982 Increases the eligibility income from 200 percent of federal poverty level to 250 percent of federal poverty level.

1999

No legislation enacted.

1998

HJR 269 RESOLUTION: Continued the HIV Joint Standing Committee for two years with two meetings per year. Membership consists of 31 members, including eight new members, four from the House of Delegates and four from the Senate.

1997

SB 1050 Includes in the definition of public safety employee, those individuals who are victims of or witnesses to a specific crime or any person providing assistance to a public safety agency employee, if such victims, witnesses or assisting persons have been involved in a possible exposure-prone incident, for only the purpose of accessing the procedure relating to notice, consent and testing of persons for blood-borne pathogens. (*§*32.1-45.2)

HB 2174 Public safety employees; testing for blood-borne pathogens; procedure available for certain citizens; definitions (*§* 32.1-45.2).

Revised March, 2001

HB 2416 Added law enforcement officers to deemed consent legislation (§ 32.1-45.1).

HB 2647 Expanded HB 1974 to require that insurance applicants, or their designees, be advised of HIV test results (§38.2-613:01).

HB 2764 Required blood-borne pathogen training for all school personnel having direct contact with children, and established a notification procedure in the case of exposure-prone incidents (§22.1-271.3).

SB 828 Allowed for the voluntary reporting of additional information at the request of the Virginia Department of Health for special surveillance or other epidemiological studies (§32.1-36).

1996

HB 1148 Continued the premium assistance program for HIV positive individuals, and allowed for other funding sources in addition to Ryan White (§32.1-330.1).

HJR 132 RESOLUTION: Continued the HIV Joint Subcommittee as a standing subcommittee to meet once each year for two years.

1995

HB 1921 Required practitioners to advise pregnant women in their care about the value of HIV testing and to request that they consent to testing (§54.1-2403.01).

HB 1922 Required testing of gamete donors (§32.1-45.3).

1994

HB 485 Established a Premium Assistance Program for HIV positive individuals (§32.1-330.1).

HB 673 Legislation enacted that addresses the issue of mental health service providers and the duty to protect third parties. (§54.1-2403.2)

SB 395 Expanded deemed consent legislation to include individuals who render emergency care or assistance at accident scenes or en route to medical care (§32.1-45.1).

1993

HB 2158 Amended confidentiality of HIV test results to allow for release of mother's HIV status to pediatricians caring for child. Also provided for release of information to Departments of Health outside VA (§32.1-36.1).

SB 682 Amended confidentiality of HIV test results to allow release to "other legal custodian" of a minor (§32.1-36.1).

SB 829 Expanded deemed consent legislation to include Hepatitis B and C (§32.1-45.1).

Revised March, 2001

SB 853 Expanded HIV testing of those convicted of sexual assault to include juveniles (§18.2-62).

HB 2391 Amended isolation procedures to specify management of airborne illness (§32.1-48.02).

1992

HB 568 Established a procedure for obtaining consent for HIV antibody testing in public safety agency situations involving exposure prone incidents (§32.1-45.2).

HB 337 Amended HB 815 (1990) to clarify services for victim (§18.2-62).

1991

HJR 436 RESOLUTION: Required Secretary of Health and Human Services to direct development of comprehensive AIDS plan for 1991-2000.

1990

SB 340 Provided for testing for convicted prostitutes (§18.2-346.1).

HB 815 Provided for testing of those charge/convicted with sexual assault (section 18.2-62)

HB 816 Established procedures for isolation of certain persons with communicable disease (amended 1993 HB 2391). (§32.1-43, 32.1-44 and 32.1-45, added § 32.1-48.01 through 32.1-48.04).

HB 814 Provided immunity to health care professionals who receive HIV test results who do not release results to others permitted to receive these results (§32.1-38)

1989

HB 1974 Comprehensive legislation which provided the following:
Development of model guidelines for school attendance for children infected with HIV (§22.1-271.3). Development of HIV education for college students (§239.2:3.2).
Establishment of a services and education grants program (§32.1-11.1)
Establishment of pilot treatment centers and regional AIDS resources and consultation centers (§32.1-11.2)
Mandatory reporting of HIV test results (§32.1-36).
Confidentiality of test results (amended 1990 HB 814, 1993 HB 2158, 1993 SB 682), (§32.1-36.1).
Counseling requirements for HIV testing (§32.1-37.2).

Situations involving deemed consent to testing (amended 1993 SB 829, 1994 SB 395) (§32.1-45.1).
Additional anonymous testing sites. (§32.1-55.1).

Prohibition of donating blood, body fluids, organs, and tissues by persons infected with HIV (§32.1-289.2), (§32.1-36 and 32.1-39; added § 2.1-51.14.1, 22.1-271.3, 23-9.2:3.2, 32.1-11.1, 32.1-11.2, 32.1-36.1, 32.1-37.2, 32.1-45.1, 32.1-55.1 and 32.1-289.2)

1988

HB 652 Required hospitals, nursing homes, homes for adults, and correctional facilities to notify funeral homes if the individual they are transferring to them was known to have had any infectious disease prior to death (§32.1-37.1 and 54-260.74:2).

HB 1092 Required health care facilities to notify emergency medical services agencies if a patient they have been asked to transfer has an infectious disease (§32.1-116.3).

SJR 31 Established a joint subcommittee to study AIDS, charged with evaluating needs and services, reviewing state policies, laws and regulations, and making recommendations for legislation.

1983

Emergency regulation by Governor required physician reporting of AIDS cases to Department of Health.

VIRGINIA HIV/AIDS LEGISLATION BY SUBJECT

CONFIDENTIALITY

HB 1974 (1989) Confidentiality of test results (§32.1-36.1).

HB 814 (1990) Amended HB 1974; Immunity to health care professionals (§32.1-38)

HB 2158 (1993) Amended HB 1974; allow release of mother's HIV status to pediatricians caring for child; also provided for release of info to departments of health outside VA (§32.1-36.1).

SB 682(1993) Amended HB 1974; allow release of test results to "other legal custodian" of a minor (§32.1-36.1).

DEEMED CONSENT

HB 1974 (1989) Covered situations involving deemed consent to testing Health care providers, patients (§32.1-45.1).

SB 829(1993) Expanded deemed consent legislation to include Hepatitis B and C (§32.1-45.1)

SB 395(1994) Expanded deemed consent legislation to include individuals who render emergency care or assistance at accident scenes or en route to medical care (§32.1-45.1).

HB 2416 (1997) Expanded deemed consent to include law enforcement officers (§32.1-45.1).

EDUCATION

HB 1974 (1989) Development of HIV education for college students (§23.9.2:3.2) Establishment of a services and education grants program (§32.1-11.2)

HB 2764 (1997) School personnel training (§22.1-271.3).

INFORMED CONSENT

HB 1974 (1989) Informed consent for testing for HIV (§32.1-37.2).

HB 1921 (1995) Required practitioners to advise pregnant women in their care about the value of HIV testing and to request that they consent to testing. (§54.1-2403.01).

Revised March, 2001

INSURANCE

HB 816 (1990) Established procedures for isolation of certain persons with communicable disease (Insurance Reg. #34, chapter 180, for AIDS); (§32.1-43, 32.1-44 and 32.1-45, added § 32.1-48.01 through 32.1-48.04)

HB 2647 (1997) Expanded HB 1974 to require that insurance applicants, or their designees, be advised of HIV test results (§38.2-613:01).

MANDATORY TESTING

HB 815 (1990) Testing of those charged/convicted with sexual assault (§18.2-62).

SB 340(1990) Testing of convicted sex workers (§18.2-346.1).

SB 853(1993) Expanded HIV testing of those convicted of sexual assault to include juveniles (§18.2-62).

HB 1922 (1995) Required testing of gamete donors (§32.1-45.3).

NOTIFICATION/REPORTING

HB 652 (1988) Required hospitals, nursing homes, homes for adults, and correctional facilities to notify funeral homes if the individual they are transferring to them was known to have had an infectious disease prior to death (§32.1-37.1 and 54-260.74.2).

HB 1092 (1988) Required health care facilities to notify emergency medical services agencies if a patient they have been asked to transfer has an infectious disease (§32.1-116.3).

HB 1974 (1989) Reporting of infectious disease, reporting by physicians and lab directors. Mandatory reporting of HIV test results. (§32.1-36)

HB 814 (1990) Provided immunity to health care professionals who receive HIV test results who do not release results to others permitted to receive these results (§32.1-38).

HB 2158 (1993) Provided for release of info to departments of health outside VA (§32.1-36.1).

HB 673 (1994) Legislation enacted that addresses the issue of mental health service providers and the duty to protect third parties. (§54.1-2403.2)

HB 2647 (1997) Expanded HB 1974 to require that insurance applicants, or their designees, be advised of HIV test results within five business days (§38.2-613:01).

HB 2764 (1997) Notification of health departments of exposure incidents in schools (§22.1-271.3).

Revised March, 2001

SB 828(1997) Allowed for the voluntary reporting of additional information at the request of the Virginia Department of Health for special surveillance or epidemiological studies (§32.1-36).

PARTNER NOTIFICATION

HB 1974 (1989) Required that partner notification service be offered to individuals tested for HIV (§32.1-37.2).

PLANNING

HJR 31 (1988) Established a joint subcommittee to study AIDS, charged with evaluating and services, reviewing state policies, laws and regulations, and making recommendations for legislation.

HJR 436 (1991) Required Secretary of Health and Human Services to direct development of comprehensive AIDS for 1991-2000.

HJR 132 (1996) Changed joint subcommittee on HIV to a standing committee which would meet once a year for two years.

PROCEDURES

HB 1974 (1989) Prohibited of donating blood, body fluids, organs, and tissues sons infected with HIV (§32.1-289.2).

HB 816 (1990) Established procedures for isolation of certain persons with communicable disease (§32.1-48.01 through 32.1-48.04).

HB 568 (1992) Established a procedure for obtaining consent for HIV antibody testing in public safety agency situations involving exposure prone incidents (§2.1-45.2)

HB 2391 (1993) Amended isolation procedures (above) to specify management of airborne illness (§32.1-48.02).

SCHOOL ATTENDANCE

HB 1974 (1989) Development of model guidelines for school attendance for children infected with HIV (§22.1-271.3).

SERVICES/PROGRAMS

HB 1974 (1989) Establishment of pilot treatment centers and regional AIDS resource and consultation centers (§32.1-11.2).

HB 337 (1992) Services for victims of sexual assault (§18.2-62).

HB 485 (1994) Established a premium assistance program for HIV positive individuals (§32.1-330.1).

Revised March, 2001

HB 1148 (1996) Continued premium assistance program, and allowed for other funding sources in addition to Ryan White (§32.1-330.1).

SEXUAL BATTERY

HB 141 (2000) Creates the Class 6 felony of infected sexual battery when the offender has intimate sexual contact with someone knowing he is infected with HIV, Syphilis or Hepatitis B with the intent to transmit the infection to another person (§18.2-67.4:1).

TATTOOING AND BODY PIERCING

HB 1823 (2001) This bill revises the authority of local governments to regulate tattoo parlors and body-piercing salons by adding specification of procedures for enforcement of compliance with disease control and disclosure requirements and requiring those localities that choose to regulate tattoo parlors and body-piercing salons to authorize unannounced inspections by appropriate personnel (§15.2-912 and 18.2-371.3)

TESTING AND COUNSELING

HB 1974 (1989) Mandatory reporting of HIV test results, confidentiality of testing, counseling requirements for HIV testing, additional anonymous testing sites (§32.1-36, 32.1-36.1, 32.1-37.2, and 32.1-55.1).

SB 1050 (1997) Includes in the definition of public safety employee, those individuals who are victims of or witnesses to a specific crime or any person providing assistance to a public safety agency employee, if such victims, witnesses or assisting persons have been involved in a possible exposure-prone incident, for only the purpose of accessing the procedure relating to notice, consent and testing of persons for blood-borne pathogens (§32.1-45.2).

HB 2174 (1997) Individual providing assistance to public safety personnel, and a victim or witness to a crime (§32.1-45.2).

SB 824 (2001) Amend the existing provision that allows the court to order HIV testing of persons charged with certain crimes to establish a procedure for a defendant whose competence is at issue. Prior to ordering testing a hearing must be held to determine that there is probable cause that the individual committed the crime (§18.2-62).

HB 652

Section 32.1-37.1 and 54-260.74:2, NOTIFICATION/REPORTING:

(1988) Required hospitals, nursing homes, homes for adults, and correctional facilities to notify funeral homes if the individual they are transferring to them was known to have had an infectious disease prior to death.

1988 SESSION

VIRGINIA ACTS OF ASSEMBLY - CHAPTER

An Act to amend the Code of Virginia by adding sections numbered 32.1-37.1 and 54-260.74:2, relating to the reporting of diseases infecting dead human bodies.

[H 652]

NONCERTIFIED COPY

Approved

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding sections numbered 32.1-37.1 and 54-260.74:2 as follows:

§ 32.1-37.1. Report of diseases infecting dead human bodies.—Upon transferring custody of any dead body to any person practicing funeral services or his agent, any hospital, nursing home, home for adults, or correctional facility shall, at the time of transfer, notify the person practicing funeral services or his agent if the individual was known to have had immediately prior to death an infectious disease which may be transmitted through exposure to any bodily fluids.

§ 54-260.74:2. Confidentiality of information on infectious diseases.—All information received by any person practicing funeral services or his agent regarding the fact that any dead body which they have received harbors an infectious disease shall be confidential, and disclosure of such information shall be grounds for disciplinary action against the funeral service licensee pursuant to § 54-260.74.

Any facility or members of its staff specified in § 32.1-37.1 shall not be liable for injury resulting from ordinary negligence in failing to identify, as herein prescribed, a dead body of a person known to have had an infectious disease immediately prior to death.

Notification that a dead body harbors an infectious disease will not constitute grounds for any funeral director's refusal to accept the body.

The Board of Health shall determine the infectious diseases for which notification is required pursuant to this section.

_____

President of the Senate

_____

Speaker of the House of Delegates

Approved:

_____

Governor

HB 1092

Section 32.1-111.3, Notification/Reporting:

(1988) Health care facilities required to notify emergency medical services agencies if a patient they have been asked to transfer has an infectious disease.

1988 SESSION

LD2689548

HOUSE BILL NO. 1092
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the House Committee on Health, Welfare and Institutions
on February 11, 1988)
(Patron Prior to Substitute--Delegate Plum)

A BILL to amend the Code of Virginia by adding in Article 3.1 of Chapter 4 of Title 32.1 a section numbered 32.1-116.3, relating to reporting of infectious diseases.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 3.1 of Chapter 4 of Title 32.1 a section numbered 32.1-116.3 as follows:

§ 32.1-116.3. Reporting of infectious diseases.--Every licensed health care facility and every local or state correctional facility which transfers or receives patients via emergency medical services ambulances or mobile intensive care units shall notify the emergency medical services agencies providing such patient transport of the name and telephone number of the individual who has been appointed as the infectious disease control officer with the responsibility of investigating exposure to infectious diseases in the facility.

Every licensed emergency medical services agency established in the Commonwealth shall notify all facilities to which they transport patients or from which they transfer patients of the names and telephone numbers of the members, not to exceed three persons, who have been appointed to serve as the infectious disease liaison officers.

Upon requesting any licensed emergency medical services agency to transfer a patient who is known to be positive for or who suffers from any infectious disease which, in the judgment of the physician authorizing the transfer or the facility's infectious disease control officer, presents any risk to the transporting emergency medical services personnel or to patients who may be subsequently transported in the same vehicle, the transferring facility shall inform the attendant-in-charge of the transferring crew of the general condition of the patient and the types of precautions to be taken to prevent the spread of the disease. The identity of the patient shall be confidential.

If, during the course of medical care and treatment, any physician determines that a patient who was transported to a receiving facility by any licensed emergency medical services agency is positive for or has been diagnosed as suffering from an infectious disease, then the infectious disease control officer in the facility shall immediately notify the infectious disease liaison officer who represents the transporting emergency medical services agency of the name of the patient, and the date and time of the patient's admittance to the facility. The infectious disease liaison officer for the transporting emergency medical services agency shall investigate the incident to determine if any exposure of emergency medical services personnel or other emergency personnel occurred. The identity of the patient and all personnel involved in any such investigation shall be confidential.

If any firefighter, emergency medical services technician or paramedic shall be exposed to an infectious disease, the infectious disease liaison officer shall immediately notify the infectious disease control officer of the receiving facility. The infectious disease control officer of the facility shall conduct an investigation and provide information concerning the extent and severity of the exposure and the recommended course of action to the infectious disease liaison officer of the transporting agency.

Any person who, as a result of this provision, becomes aware of the identity or condition of a person known to be positive for or to suffer from any infectious disease, or to have suffered exposure to an infectious disease, shall keep such information confidential, except as expressly authorized by this provision.

No person known to be positive for or to suffer from any infectious disease shall be refused transportation service for that reason by an emergency medical services agency.

HB 1974

Section 32.1-36, 32.1-36.1, 32.1-37.2, 32.1-55.1, 22.1-271.3, 32.1-11.2, 32.1-289.2, 32.1-37.2, 32.1-36, 32.1-37.2, 32.1-11.2, 23.9.2:3.2, 32.1-45.1, 32.1-36.1, CONFIDENTIALITY, DEEMED CONSENT, EDUCATION, INFORMED CONSENT, NOTIFICATION/REPORTING, PARTNER NOTIFICATION, PROCEDUCRES, SERVICES/PROGRAMS, SCHOOL ATTENDANCE, & TESTING AND COUNSELING:

(1989) Established confidentiality of test results. Situations involving deemed consent to testing were covered for health care providers and patients. The development of HIV education for college students was established, along with a services and education grants program. Established procedures for informed consent of HIV testing. Physicians and lab directors were mandated to report HIV test results. Partner notification service offered to individuals tested for HIV. People infected with HIV were prohibited from donating blood, body fluids, organs, and tissues. Pilot treatment centers and regional AIDS resource and consultation centers were established. Model guidelines for school attendance for children infected with HIV developed. Mandatory reporting of HIV test results, confidentiality of testing, counseling requirements for HIV testing, and the addition of anonymous testing sites.

1989 SESSION

VIRGINIA ACTS OF ASSEMBLY - CHAPTER 613

An Act to amend and reenact §§ 32.1-36 and 32.1-39 of the Code of Virginia and to amend the Code of Virginia by adding sections numbered 2.1-51.14:1, 22.1-271.3, 23-9.2:3.2, 32.1-11.1, 32.1-11.2, 32.1-36.1, 32.1-37.2, 32.1-45.1, 32.1-55.1 and 32.1-289.2, relating to infection with human immunodeficiency virus; penalties.

[H 1974]

Approved MAR 2 5 1989

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-36 and 32.1-39 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 2.1-51.14:1, 22.1-271.3, 23-9.2:3.2, 32.1-11.1, 32.1-11.2, 32.1-36.1, 32.1-37.2, 32.1-45.1, 32.1-55.1 and 32.1-289.2 as follows:

§ 2.1-51.14:1. Responsibility of certain agencies within the Secretariat.—The Boards of Health, Mental Health, Mental Retardation and Substance Abuse Services, Rehabilitative Services, Social Services, and Medical Assistance Services shall review their regulations and policies related to service delivery in order to ascertain and eliminate any discrimination against individuals infected with human immunodeficiency virus.

§ 22.1-271.3. Guidelines for school attendance for children infected with human immunodeficiency virus.—A. The Board of Education, in cooperation with the Board of Health, shall develop, and revise as necessary, model guidelines for school attendance for children infected with human immunodeficiency virus. The first such guidelines shall be completed by December 1, 1989. The Board shall distribute copies of these guidelines to each division superintendent and every school board member in the Commonwealth immediately following completion.

B. Each school board shall, by July 1, 1990, adopt guidelines for school attendance for children with human immunodeficiency virus. Such guidelines shall be consistent with the model guidelines for such school attendance developed by the Board of Education.

§ 23-9.2:3.2. Education program on human immunodeficiency virus infection.—A. Virginia public colleges and universities, in cooperation with the State Council of Higher Education and the Department of Health, shall develop, and revise as necessary, a model education program for college students on the etiology, effects and prevention of infection with human immunodeficiency virus. The Council shall also encourage private colleges and universities to develop such programs.

B. Each board of visitors or other governing body of a public institution of higher education shall, by July 1, 1990, adopt an education program on human immunodeficiency virus infection for the students in its institution.

§ 32.1-11.1. Board to establish acquired immunodeficiency syndrome services and education grants program.—With such funds as are appropriated for this purpose, the Board of Health shall establish the acquired immunodeficiency syndrome services and education grants program. The Board may award grants for (i) the provision of direct patient services including, but not limited to, mental health services, and home and community based health services; and (i) broad-based community AIDS education efforts including, but not limited to, education of high risk populations, street outreach efforts and improvement of public knowledge, awareness and attitudes about human immunodeficiency virus infection and persons with acquired immunodeficiency syndrome.

The Board shall appoint an advisory committee of experts in the delivery of services to persons with AIDS and AIDS education to assist in the development of the criteria for awarding such grants, the contents of the request for proposals, evaluation and ranking of the applications and making recommendations for the awarding of the grants.

§ 32.1-11.2. Regional AIDS resource and consultation centers; pilot treatment centers.—Utilizing existing state and local facilities and from such funds as are appropriated for this purpose, the Board of Health shall provide grants for no more than five regional AIDS resource and consultation centers and two pilot treatment centers.

Each regional AIDS resource and consultation center shall be designed to address the need for expanded medical care and support services for persons with human immunodeficiency virus infection through education of health care professionals on a broad range of AIDS-related issues, clinical training for health care practitioners and students, medical consultation to community physicians and other health care providers, provision of current technical medical materials such as manuals and protocols for the management of HIV infection and medical literature, facilitation of access to health services, mental

health and substance abuse services, support services and case management for HIV-infected persons. The regional AIDS resource and consultation centers shall cooperate with at least one of the medical schools located in the Commonwealth.

Each pilot treatment center shall supply medical care and support services for persons with human immunodeficiency virus infection.

The Board shall establish criteria for award of the grants. The criteria for the grants for the regional AIDS resource and consultation centers shall include, but not be limited to: (i) priority targeting of funds for services to high risk populations; (ii) geographical distribution of the centers in order to provide equal access to services throughout the Commonwealth; (iii) pro rata apportionment of funds according to the number of cases of acquired immunodeficiency syndrome in the various areas of the Commonwealth; (iv) development of innovative and flexible approaches to provision of services tailored to the specific needs of patients in the region; and (v) extensive community involvement.

§ 32.1-36. Reports by physicians and laboratory directors.–A. Every physician practicing in this Commonwealth who shall diagnose or reasonably suspect that any patient of his has any disease required by the Board to be reported and every director of any laboratory doing business in this Commonwealth which performs any test whose results indicate the presence of any such disease shall make a report within such time and in such manner as may be prescribed by regulations of the Board.

B. Any physician who diagnoses a venereal disease in a child twelve years of age or under shall, in addition to the requirements of subsection A hereof, report the matter, in accordance with the provisions of § 63.1-248.3, unless the physician reasonably believes that the infection was acquired congenitally or by a means other than sexual abuse.

C. Any physician practicing in this Commonwealth ~~may~~ *shall* report to the local health department the identity of any patient of his who has tested positive for exposure to human immunodeficiency virus as demonstrated by such test or tests as are approved by the Board for this purpose. *However, there is no duty on the part of the physician to notify any third party other than the local health department of such test result, and a cause of action shall not arise from any failure to notify any other third party.*

§ 32.1-36.1. Confidentiality of test for human immunodeficiency virus; civil penalty; individual action for damages or penalty.– A. The results of every test to determine infection with human immunodeficiency virus shall be confidential. Such information may only be released to the following persons:

1. The subject of the test or his legally authorized representative.

2. Any person designated in a release signed by the subject of the test or his legally authorized representative.

3. The Department of Health.

4. Health care providers for purposes of consultation or providing care and treatment to the person who was the subject of the test.

5. Health care facility staff committees which monitor, evaluate, or review programs or services.

6. Medical or epidemiological researchers for use as statistical data only.

7. Any person allowed access to such information by a court order.

8. Any facility which procures, processes, distributes or uses blood, other body fluids, tissues or organs.

9. Any person authorized by law to receive such information.

10. The parents of the subject of the test if the subject is a minor.

11. The spouse of the subject of the test.

B. In any action brought under this section, if the court finds that a person has willfully or through gross negligence made an unauthorized disclosure in violation of this section, the Attorney General, any Attorney for the Commonwealth, or any attorney for the county, city or town in which the violation occurred may recover for the Literary Fund, upon petition to the court, a civil penalty of not more than $5,000 per violation.

C. Any person who is the subject of an unauthorized disclosure pursuant to this section shall be entitled to initiate an action to recover actual damages, if any, or $100, whichever is greater. In addition, such person may also be awarded reasonable attorney's fees and court costs.

§ 32.1-37.2. Informed consent for testing for human immunodeficiency virus; condition on disclosure of test results; counseling required; exceptions.–A. Prior to performing any test to determine infection with human immunodeficiency virus, the subject of the test shall be given an oral or written explanation of the meaning of the test. Except as otherwise authorized in this Code, informed consent shall be obtained before such a test is performed.

health services areas of the Commonwealth anonymous testing for infection with human immunodeficiency virus.

§ 32.1-289.2. Donation or sale of blood, body fluids, organs and tissues by persons infected with human immunodeficiency virus.—Any person who donates or sells, who attempts to donate or sell, or who consents to the donation or sale of blood, other body fluids, organs and tissues, knowing that the donor is, or was, infected with human immunodeficiency virus, and who has been instructed that such blood, body fluids, organs or tissues may transmit the infection, shall be guilty, upon conviction, of a Class 6 felony.

This section shall not be construed to prohibit the donation of infected blood, other body fluids, organs and tissues for use in medical or scientific research.

2. That § 32.1-37.2 of this act shall become effective on October 1, 1989.

President of the Senate

Speaker of the House of Delegates

Approved:

Governor

SB 340

Section 18.2-346.1, Mandatory Testing:

(1990) Provided for testing for convicted sex workers.

1990 SESSION

LD2021110

SENATE BILL NO. 340

Offered January 23, 1990

A BILL to amend the Code of Virginia by adding in Article 3 of Chapter 8 of Title 18.2 a section numbered 18.2-346.1, relating to testing of persons convicted of prostitution for infection with human immunodeficiency virus.

Patron--Chichester

Referred to the Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 3 of Chapter 8 of Title 18.2, a section numbered 18.2-346.1 as follows:

§ 18.2-346.1. Testing of convicted prostitutes for infection with human immunodeficiency virus.--As soon as practicable following conviction of any person for prostitution, such person shall be required to submit to testing for infection with human immunodeficiency virus. The convicted person shall receive counseling from personnel of the Department of Health concerning (i) the meaning of the test, (ii) acquired immunodeficiency syndrome and (iii) the transmission and prevention of infection with human immunodeficiency virus.

Tests shall be conducted to confirm any initial positive test results before any test result shall be determined to be positive for infection. The results of such test shall be confidential as provided in § 32.1-36.1 and shall only be disclosed to the person who is the subject of the test and to the Department of Health as required by § 32.1-36. The Department shall conduct surveillance and investigation in accordance with the requirements of § 32.1-39.

The results of the test shall not be admissible in any criminal proceeding related to prostitution.

The cost of the test shall be paid by the Commonwealth and taxed as part of the cost of such criminal proceedings.

Official Use By Clerks	
Passed By The Senate	**Passed By The House of Delegates**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
Clerk of the Senate	Clerk of the House of Delegates

HB 815

Section 18.2-62 MANDATORY TESTING:

(1990) HIV testing mandated for those charged or convicted with sexual assault.

HP2022466

1990 SESSION
ENGROSSED

HOUSE BILL NO. 815

House Amendments in [ ] - February 11, 1990

A BILL to amend the Code of Virginia by adding in Article 7 of Chapter 4 of Title 18.2 a section numbered 18.2-62, relating to testing of persons for human immunodeficiency virus.

Patrons--Glasscock, Harris, E.R., Stambaugh and Wilkins; Senators: Earley, Nolen, Miller, Y.B., DuVal and Chichester

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Referred to the Committee on Health, Welfare and Institutions

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Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 7 of Chapter 7 of Title 18.2 a section numbered 18.2-62 as follows:

§ 18.2-62. Testing of certain persons for human immunodeficiency virus.--A. As soon as practicable following arrest, the attorney for the Commonwealth may request, after consultation with any victim, that any person charged with any crime involving sexual assault pursuant to this article or any offenses against children as prohibited by §§ 18.2-361, 18.2-366, 18.2-370, and 18.2-370.1 be requested to submit to testing for infection with human immunodeficiency virus. The person so charged shall be counseled about the meaning of the test, about acquired immunodeficiency syndrome, and about the transmission and prevention of infection with human immunodeficiency virus.

In the event the person so charged refuses to submit to the test, a hearing shall be conducted in camera before the [circuit] court to determine probable cause by a preponderance of the evidence that the individual has committed the crime with which he is charged. Upon a finding of probable cause, the court shall order the accused to undergo testing for infection with human immunodeficiency virus.

B. Upon conviction of any crime involving sexual assault pursuant to this article or any offenses against children as prohibited by §§ 18.2-361, 18.2-366, 18.2-370 and 18.2-370.1, the attorney for the Commonwealth may request, after consultation with any victim, and the court shall order the defendant to submit to testing for infection with human immunodeficiency virus. Any test conducted following conviction shall be in addition to such tests as may have been conducted following arrest pursuant to subsection A.

C. Confirmatory tests shall be conducted before any test result shall be determined to be positive. The results of the tests for infection with human immunodeficiency virus shall be confidential as provided in § 32.1-36.1; however, the Department of Health shall disclose the results to any victim and conduct surveillance and investigation in accordance with § 32.1-39 of this Code.

The results of such tests shall not be admissible as evidence in any criminal proceeding involving the charge initiating the tests.

The cost of such tests shall be paid by the Commonwealth and taxed as part of the cost of such criminal proceedings.

HB 816

Section 32.1-43, 32.1-44, 32.1-45, added section 32.1-48.01 through 32.1-48.04, INSURANCE and PROCEDURES:

(1990) Procedures established for isolation of certain persons with communicable diseases. Established procedures for isolation of certain persons with communicable disease. (Insurance Reg. #34, chapter 180, for AIDS)

1990 SESSION

VIRGINIA ACTS OF ASSEMBLY - CHAPTER

An Act to amend and reenact §§ 32.1-43, 32.1-44 and 32.1-45 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 2 of Title 32.1, an article numbered 3.01, consisting of sections numbered 32.1-48.01 through 32.1-48.04 and to repeal §§ 32.1-51 and 32.1-52 of the Code of Virginia, all relating to isolation of certain persons infected with communicable diseases.

[H 816]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-43, 32.1-44 and 32.1-45 of the Code of Virginia are amended and reenacted and the Code of Virginia is amended by adding in Chapter 2 of Title 32.1, an article numbered 3.01, consisting of sections numbered 32.1-48.01 through 32.1-48.04, as follows:

§ 32.1-43. Authority of Commissioner to require quarantine, etc.—The Commissioner shall have authority to require ~~isolation,~~ quarantine, vaccination or treatment of any individual when he determines any such measure to be necessary to control the spread of any disease of public health importance.

§ 32.1-44. Isolated or quarantined person may choose method of treatment.— ~~Nothing contained in §§ 32.1-42 and 32.1-43~~ *The provisions of this chapter* shall *not* be construed to prevent or restrict any isolated or quarantined person from choosing his own method of treatment or to limit any diseased person in his right to choose or select whatever method or mode of treatment he may believe to be the most efficacious in the cure of his ailment.

§ 32.1-45. Expense of treatment.— ~~Any person required to be treated pursuant to § 32.1-42 or § 32.1-43 shall bear~~ *Except as specifically provided by law, the provisions of this chapter shall not be construed as relieving any individual of* the expense, if any, of ~~such~~ *any* treatment.

Article 3.01.

Isolation Of Certain Persons With Communicable Diseases.

§ 32.1-48.01. Definitions.—As used in this article, unless the context requires a different meaning:

"Appropriate precautions" means those specific measures which have been demonstrated by current scientific evidence to assist in preventing transmission of a communicable disease. Appropriate precautions will vary according to the disease.

"At-risk behavior" means engaging in acts which a person, who has been informed that he is infected with a communicable disease, which he knows may infect other persons without taking appropriate precautions to protect the health of the other persons.

"Communicable disease" means an illness of public health significance, as determined by the Commissioner of Health, caused by a specific infectious agent which may be transmitted directly or indirectly from one person to another.

§ 32.1-48.02. Investigations of verified reports or medical evidence; counseling.—A. Upon receiving at least two verified reports or upon receiving medical evidence that any person who is reputed to know that he is infected with a communicable disease is engaging in at-risk behavior, the Commissioner may conduct an investigation through an examination of the records of the Department and other medical records to determine the disease status of the individual and that there is cause to believe he is engaging in at-risk behavior.

B. If the investigation indicates that the person has a communicable disease and that there is cause to believe he is engaging in at-risk behavior, the Commissioner may issue an order for such person to report to the local or district health department in the jurisdiction in which he resides to receive counseling on the etiology, effects and prevention of the specific disease. The person conducting the counseling shall prepare and submit a report to the Commissioner on the counseling session or sessions in which he shall document that the person so counseled has been informed about the acts that constitute at-risk behavior, appropriate precautions, and the need to use appropriate precautions. The counselor shall also report any statements indicating the intentions or understanding of the person so counseled.

§ 32.1-48.03. Petition for hearing; temporary detention.—A. Upon receiving a verified report or upon receiving medical evidence that any person who has been counseled pursuant to § 32.1-48.02 has continued to engage in at-risk behavior, the Commissioner may petition the general district court of the county or city in which such person resides

HB 2158

Section 32.1-36.1, CONFIDENTIALITY and NOTIFICATION/REPORTING:

(1993) Expanded HB 1974 to allow the release of a mother's HIV status to pediatricians caring for a child. Also provided for the release of information to departments of health outside of Virginia.

1993 SESSION

VIRGINIA ACTS OF ASSEMBLY - CHAPTER 664

An Act to amend and reenact §§ 32.1-11.2 and 32.1-36.1 of the Code of Virginia, relating to certain AIDS programs and confidentiality of test for human immunodeficiency virus.

[H 2158]

Approved MAR 2 8 1993

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-11.2 and 32.1-36.1 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-11.2. Regional AIDS resource and consultation centers; HIV centers.—Utilizing existing state and local facilities and from such funds as are appropriated for this purpose, the Board of Health shall provide grants for no more than five regional AIDS resource and consultation centers and two ~~pilot treatment~~ *HIV early intervention* centers.

Each regional AIDS resource and consultation center shall be designed to address the need for expanded medical care and support services for persons with human immunodeficiency virus infection through education of health care professionals on a broad range of AIDS-related issues, clinical training for health care practitioners and students, medical consultation to community physicians and other health care providers, provision of current technical medical materials such as manuals and protocols for the management of HIV infection and medical literature, facilitation of access to health services, mental health and substance abuse services, support services and case management for HIV-infected persons. The regional AIDS resource and consultation centers shall cooperate with at least one of the medical schools located in the Commonwealth.

Each ~~pilot treatment~~ *HIV early intervention* center shall supply medical care and support services for persons with human immunodeficiency virus infection *in accordance with its agreement with the Commissioner of Health* .

The Board shall establish criteria for award of the grants. The criteria for the grants for the regional AIDS resource and consultation centers shall include, but not be limited to: (i) priority targeting of funds for services to high risk populations; (ii) geographical distribution of the centers in order to provide equal access to services throughout the Commonwealth; (iii) pro rata apportionment of funds according to the number of cases of acquired immunodeficiency syndrome in the various areas of the Commonwealth; (iv) development of innovative and flexible approaches to provision of services tailored to the specific needs of patients in the region; and (v) extensive community involvement.

§ 32.1-36.1. Confidentiality of test for human immunodeficiency virus; civil penalty; individual action for damages or penalty.—A. The results of every test to determine infection with human immunodeficiency virus shall be confidential. Such information may only be released to the following persons:

1. The subject of the test or his legally authorized representative.
2. Any person designated in a release signed by the subject of the test or his legally authorized representative.
3. The Department of Health.
4. Health care providers for purposes of consultation or providing care and treatment to the person who was the subject of the test *or providing care and treatment to a child of a woman who, at the time of such child's birth, was known to be infected with human immunodeficiency virus* .
5. Health care facility staff committees which monitor, evaluate, or review programs or services.
6. Medical or epidemiological researchers for use as statistical data only.
7. Any person allowed access to such information by a court order.
8. Any facility which procures, processes, distributes or uses blood, other body fluids, tissues or organs.
9. Any person authorized by law to receive such information.
10. The parents of the subject of the test if the subject is a minor.
11. The spouse of the subject of the test.

12. Departments of health located outside the Commonwealth by the Virginia Department of Health for the purposes of disease surveillance and investigation.

B. In any action brought under this section, if the court finds that a person has willfully or through gross negligence made an unauthorized disclosure in violation of this section,

the Attorney General, any attorney for the Commonwealth, or any attorney for the county, city or town in which the violation occurred may recover for the Literary Fund, upon petition to the court, a civil penalty of not more than $5,000 per violation.

C. Any person who is the subject of an unauthorized disclosure pursuant to this section shall be entitled to initiate an action to recover actual damages, if any, or $100, whichever is greater. In addition, such person may also be awarded reasonable attorney's fees and court costs.

D. This section shall not be deemed to create any duty on the part of any person who receives such test results, where none exists otherwise, to release the results to a person listed herein as authorized to receive them.

2. That an emergency exists and this act is in force from its passage.

_____

President of the Senate

_____

Speaker of the House of Delegates

Approved:

_____

Governor

HB 2391

Section 32.1-47.02, PROCEDURES:

(1993) Amended isolation procedures to specify management of airborne illness.

1993 SESSION

LD8768196

HOUSE BILL NO. 2391
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the Senate Committee on Education and Health on February 18, 1993)
(Patron Prior to Substitute—Delegate Darner)

A BILL to amend and reenact § 32.1-48.02 of the Code of Virginia, relating to isolation of certain persons with communicable diseases.

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-48.02 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-48.02. Investigations of verified reports or medical evidence; counseling; outpatient and emergency treatment orders; custody upon emergency order.—A. Upon receiving at least two verified reports or upon receiving medical evidence that any person who is reputed to know that he is infected with a communicable disease is engaging in at-risk behavior, the Commissioner or his designee may conduct an investigation through an examination of the records of the Department and other medical records to determine the disease status of the individual and that there is cause to believe he is engaging in at-risk behavior.

B. If the investigation indicates that the person has a communicable disease *caused by a non-airborne microorganism* and that there is cause to believe he is engaging in at-risk behavior, the Commissioner or his designee may issue an order for such person to report to the local or district health department in the jurisdiction in which he resides to receive counseling on the etiology, effects and prevention of the specific disease. The person conducting the counseling shall prepare and submit a report to the Commissioner or his designee on the counseling session or sessions in which he shall document that the person so counseled has been informed about the acts that constitute at-risk behavior, appropriate precautions, and the need to use appropriate precautions. The counselor shall also report any statements indicating the intentions or understanding of the person so counseled.

C. If the investigation, described in subsection A, indicates that the person has a communicable disease caused by an airborne microorganism which causes serious disease and can result in death and that the person has refused or failed to adhere to a prescribed course of treatment and, despite counseling, is engaging in conduct that places uninfected persons at risk of contracting such airborne communicable disease, the Commissioner or his designee may issue an outpatient treatment order for such person to report to the local or district health department in the jurisdiction in which he resides to receive appropriate outpatient treatment and education concerning his disease.

D. If the investigation, described in subsection A, indicates that the person has a communicable disease caused by an airborne microorganism which causes serious disease and can result in death and, despite documented and appropriate counseling, is engaging in conduct that unreasonably places uninfected persons at risk of contracting such airborne communicable disease and medical data demonstrate that he poses an imminent threat to the health of others, the Commissioner may issue an emergency order requiring such person to be taken immediately into custody and placed, for a period, not to exceed forty-eight hours, in the least restrictive, willing facility providing protection of the health of others and appropriate treatment to the person upon finding that at least one of the following conditions is met:

1. The person has refused or failed to report to the local health department after having been ordered to do so pursuant to subsection C, for appropriate outpatient treatment and education concerning his disease;

2. The person has a documented history of failure to adhere to a prescribed course of treatment; or

3. Documentation exists that the person has indicated that he will not comply with the prescribed treatment.

If the specified forty-eight-hour period terminates on a Saturday, Sunday or legal holiday, such person may be detained until the next day which is not a Saturday, Sunday,

or legal holiday. In no event may the person be detained for longer than seventy-two hours or ninety-six hours when the specified forty-eight-hour period terminates on a Saturday, Sunday or legal holiday. For purposes of this subsection, a Saturday, Sunday, or legal holiday shall be deemed to include the time period up to 8:00 A.M. of the next day which is not a Saturday, Sunday, or legal holiday. During this period, the Commissioner shall proceed in accordance with § 32.1-48.03.

E. In order to implement an emergency order issued pursuant to subsection D of this section, all state and local law-enforcement officers are authorized to take custody of the subject of such emergency order immediately upon issuance of the emergency order by the Commissioner.

2. That an emergency exists and this act is in force from its passage.

Official Use By Clerks	
Passed By The House of Delegates	**Passed By The Senate**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
_____	_____
Clerk of the House of Delegates	Clerk of the Senate

SB 682

Section 32.1-36.1, Confidentiality:

(1993) Amended confidentiality of HIV test results to allow release to "other legal custodian" of a minor.

An Act to amend and reenact § 32.1-36.1 of the Code of Virginia, relating to confidentiality of test for human immunodeficiency virus.

[S 682]

Approved MAR 10 1993

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-36.1 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-36.1. Confidentiality of test for human immunodeficiency virus; civil penalty; individual action for damages or penalty.—A. The results of every test to determine infection with human immunodeficiency virus shall be confidential. Such information may only be released to the following persons:

1. The subject of the test or his legally authorized representative.

2. Any person designated in a release signed by the subject of the test or his legally authorized representative.

3. The Department of Health.

4. Health care providers for purposes of consultation or providing care and treatment to the person who was the subject of the test.

5. Health care facility staff committees which monitor, evaluate, or review programs or services.

6. Medical or epidemiological researchers for use as statistical data only.

7. Any person allowed access to such information by a court order.

8. Any facility which procures, processes, distributes or uses blood, other body fluids, tissues or organs.

9. Any person authorized by law to receive such information.

10. The parents *or other legal custodian* of the subject of the test if the subject is a minor.

11. The spouse of the subject of the test.

B. In any action brought under this section, if the court finds that a person has willfully or through gross negligence made an unauthorized disclosure in violation of this section, the Attorney General, any attorney for the Commonwealth, or any attorney for the county, city or town in which the violation occurred may recover for the Literary Fund, upon petition to the court, a civil penalty of not more than $5,000 per violation.

C. Any person who is the subject of an unauthorized disclosure pursuant to this section shall be entitled to initiate an action to recover actual damages, if any, or $100, whichever is greater. In addition, such person may also be awarded reasonable attorney's fees and court costs.

D. This section shall not be deemed to create any duty on the part of any person who receives such test results, where none exists otherwise, to release the results to a person listed herein as authorized to receive them.

SB 853

Section 18.2-62, Mandatory Testing:

(1993) Expanded HIV testing of those convicted of sexual assault to include juveniles.

1993 SESSION

VIRGINIA ACTS OF ASSEMBLY - CHAPTER 5 1 2

An Act to amend and reenact § 18.2-62 of the Code of Virginia, relating to testing of persons accused of certain sex offenses for presence of human immunodeficiency virus.

[S 853]

Approved MAR 2 4 1993

Be it enacted by the General Assembly of Virginia:

1. That § 18.2-62 of the Code of Virginia is amended and reenacted as follows:

§ 18.2-62. Testing of certain persons for human immunodeficiency virus.—A. As soon as practicable following arrest, the attorney for the Commonwealth may request, after consultation with any victim, that any person charged with any crime involving sexual assault pursuant to this article or any offenses against children as prohibited by §§ 18.2-361, 18.2-366, 18.2-370, and 18.2-370.1 be requested to submit to testing for infection with human immunodeficiency virus. The person so charged shall be counseled about the meaning of the test, about acquired immunodeficiency syndrome, and about the transmission and prevention of infection with human immunodeficiency virus.

If the person so charged refuses to submit to the test, the court with jurisdiction of the case shall, after a finding of probable cause that the individual has committed the crime with which he is charged, order the accused to undergo testing for infection with human immunodeficiency virus.

B. Upon conviction *, or adjudication as delinquent in the case of a juvenile,* of any crime involving sexual assault pursuant to this article or any offenses against children as prohibited by §§ 18.2-361, 18.2-366, 18.2-370, and 18.2-370.1, the attorney for the Commonwealth may, after consultation with any victim and, upon the request of any victim shall, request and the court shall order the defendant to submit to testing for infection with human immunodeficiency virus. Any test conducted following conviction shall be in addition to such tests as may have been conducted following arrest pursuant to subsection A.

C. Confirmatory tests shall be conducted before any test result shall be determined to be positive. The results of the tests for infection with human immunodeficiency virus shall be confidential as provided in § 32.1-36.1; however, the Department of Health shall also disclose the results to any victim and offer appropriate counseling as provided by subsection B of § 32.1-37.2. The Department shall conduct surveillance and investigation in accordance with § 32.1-39.

The results of such tests shall not be admissible as evidence in any criminal proceeding.

The cost of such tests shall be paid by the Commonwealth and taxed as part of the cost of such criminal proceedings.

President of the Senate

Speaker of the House of Delegates

Approved:

Governor

SB 395

Section 32.1-45.1, Deemed Consent:

(1994) Expanded deemed consent legislation to include individuals who render emergency care or assistance at accident scenes or en route to medical care.

1994 SESSION

LD8163665

SENATE BILL NO. 395

Offered January 25, 1994

A BILL to amend and reenact § 32.1-45.1 of the Code of Virginia, relating to consent to testing and release of test results for infection with human immunodeficiency virus and hepatitis B or C viruses.

Patrons—Goode and Waddell; Delegates: Armstrong and Reynolds

Referred to the Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-45.1 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-45.1. Deemed consent to testing and release of test results related to infection with human immunodeficiency virus or hepatitis B or C viruses.

A. Whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may, according to the then current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus or hepatitis B or C viruses, the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such patient shall also be deemed to have consented to the release of such test results to the person who was exposed. In other than emergency situations, it shall be the responsibility of the health care provider to inform patients of this provision prior to providing them with health care services which create a risk of such exposure.

B. Whenever any patient is directly exposed to body fluids of a health care provider, or of any person employed by or under the direction and control of a health care provider, in a manner which may, according to the then current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus or hepatitis B or C viruses, the person whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such person shall also be deemed to have consented to the release of such test results to the patient who was exposed.

C. For the purposes of this section, "health care provider" means any person, facility or agency licensed or certified to provide care or treatment by the Department of Health, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Rehabilitative Services, or the Department of Social Services, any person licensed or certified by a health regulatory board within the Department of Health Professions except for the Boards of Funeral Directors and Embalmers and Veterinary Medicine or any personal care agency contracting with the Department of Medical Assistance Services.

D. "Health care provider" licensed or certified to provide care or treatment by the Department of Health shall be deemed to include any person who renders emergency care or assistance, without compensation and in good faith, at the scene of an accident, fire, or any life-threatening emergency, or while en route therefrom to any hospital, medical clinic or doctor's office. The Department of Health shall provide appropriate counseling and opportunity for face-to-face disclosure of any test results to any such person.

HB 1921

Section 54.1-2403.01, INFORMED CONSENT:

(1995) Practitioners required to advise pregnant women in their care about the value of HIV testing and to request that they consent to testing.

CHAPTER 309

An Act to amend the Code of Virginia by adding a section numbered 54.1-2403.01, relating to a certain routine component of prenatal care.

[H 1921]

Approved March 16, 1995

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 54.1-2403.01 as follows:

§ 54.1-2403.01. Routine component of prenatal care.

As a routine component of prenatal care, every practitioner licensed pursuant to this subtitle who renders prenatal care, regardless of the site of such practice, shall advise every pregnant woman who is his patient of the value of testing for Human Immunodeficiency Viruses (HIV) infection and shall request of each such pregnant woman consent to such testing. The confidentiality provisions of § 32.1-36.1, the informed consent stipulations, test result disclosure conditions, and appropriate counseling requirements of § 32.1-37.2 shall apply to any HIV testing conducted pursuant to this section. Practitioners shall counsel all pregnant women with HIV-positive test results about the dangers to the fetus and the advisability of receiving treatment in accordance with the then current Centers for Disease Control recommendations for HIV-positive pregnant women. Any pregnant woman shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the patient's medical record.

HB 1922

Section 32.1-45.3, MANDATORY TESTING:

(1995) Gamete donors required to have HIV testing.

CHAPTER 519

An Act to amend and reenact § 54.1-2971.1 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 32.1-45.3, relating to HIV testing of gamete donors.

[H 1922]

Approved March 23, 1995

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2971.1 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 32.1-45.3 as follows:

§ 32.1-45.3. Certain testing of gamete donors required; Board to establish testing protocol.

Any person using donor gametes to treat patients for infertility by artificial insemination, in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer or any other gamete, zygote or embryo transfer or other intervening medical technology using sperm or ova, shall, prior to using any donor gametes for such procedures, ascertain the HIV status of the donor through testing as provided in Board of Health regulations. The Board of Health shall promulgate regulations establishing a testing protocol for gamete donors.

As used in this section:

"Donor" means an individual unrelated by marriage to the recipient who contributes the sperm or ova used in the procedures noted above.

"Gametes" means either sperm or ova.

§ 54.1-2971.1. Disclosure for certain treatment of infertility.

Before a physician commences treatment of a patient by in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer, including the administration of drugs for the stimulation or suppression of ovulation prefatory thereto, a disclosure form shall have been executed by the patient which includes, *but need not be limited to,* the rates of success for the particular procedure at the clinic or hospital where the procedure is to be performed. The information disclosed to the patient shall include the *testing protocol used to ensure that gamete donors are free from known infection with human immunodeficiency viruses, the* total number of live births, the number of live births as a percentage of completed retrieval cycles, and the rates for clinical pregnancy and delivery per completed retrieval cycle bracketed by age groups consisting of women under thirty years of age, women aged thirty through thirty-four years, women aged thirty-five through thirty-nine years, and women aged forty years and older.

HB 2174 / HB 2416

Section 32.1 - 45.2. Testing of Public Safety Workers (H2174) and Health Care Providers (H2416) for Blood-Borne Pathogens.

(1997) Expanded Code of Virginia to include "Deemed Consent" to HIV, Hepatitis B, & Hepatitis C testing in exposure incidents.

1997 SESSION

977730140

HOUSE BILL NO. 2174

Offered January 16, 1997

A BILL to amend and reenact § 32.1-45.2 of the Code of Virginia, relating to testing of certain persons for blood-borne pathogens.

Patrons—Bryant, Abbitt, Crouch and Putney; Senators: Hawkins, Howell and Newman

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-45.2 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-45.2. Public safety employees; testing for blood-borne pathogens; procedure available for certain citizens; definitions.

A. If, in the course of employment, an employee of a public safety agency is involved in a possible exposure prone incident, the employee shall immediately, or as soon thereafter as practicable, notify the agency of the incident in accordance with the agency's procedures for reporting workplace accidents.

B. If, after reviewing the facts of the possible exposure prone incident with the employee and after medical consultation, the agency concludes that it is reasonable to believe that an exposure prone incident may have occurred, (i) the agency shall request the person whose body fluids were involved to give informed consent, as provided in § 32.1-37.2, to submit to testing for hepatitis B virus and human immunodeficiency virus and to authorize disclosure of the test results or (ii) if the person is deceased, the agency shall request the custodian of the remains to preserve a specimen of blood and shall request the decedent's next of kin to provide informed consent, as provided in § 32.1-37.2, to such testing and to authorize disclosure of the test results.

C. If a person is involved in a possible exposure prone incident involving the body fluids of an employee of a public safety agency, the person may request the agency to review the facts of the possible exposure prone incident for purposes of obtaining the employee's informed consent, as provided in § 32.1-37.2, to test for hepatitis B virus and human immunodeficiency virus and to authorize disclosure of the test results. If, after reviewing the facts and after medical consultation, the agency concludes it is reasonable to believe an exposure prone incident involving the person and the employee may have occurred, (i) the agency shall request the employee whose body fluids were involved to give informed consent to submit to testing for hepatitis B virus and human immunodeficiency virus and to authorize disclosure of the test results or (ii) if the employee is deceased, the agency shall request the custodian of the remains to preserve a specimen of blood and shall request the decedent's next of kin to provide informed consent, as provided in § 32.1-37.2, to such testing and to authorize disclosure of the test results.

D. If informed consent is refused under subsection B of this section, the public safety agency or the employee may petition the general district court of the city or county in which the person resides or resided, or in the case of a nonresident, the city or county of the public safety agency's principal office, to determine whether an exposure prone incident has occurred and to order testing and disclosure of the test results.

If informed consent is refused under subsection C of this section, the person involved in the possible exposure prone incident may petition the general district court of the city or county of the public safety agency's principal office to determine whether an exposure prone incident has occurred and to order testing and disclosure of the test results.

E. If the court finds by a preponderance of the evidence that an exposure prone incident has occurred, it shall order testing for hepatitis B virus and human immunodeficiency virus and disclosure of the test results. The court shall be advised by the Commissioner or his designee in making this finding. The hearing shall be held in camera as soon as practicable after the petition is filed. The record shall be sealed.

F. A party may appeal an order of the general district court to the circuit court of the same jurisdiction within ten days from the date of the order. Any such appeal shall be de novo, in camera, and shall be heard as soon as possible by the circuit court. The circuit court shall be advised by the

VIRGINIA ACTS OF ASSEMBLY -- 1997 RECONVENED SESSION

REENROLLED

CHAPTER 869

An Act to amend and reenact § 32.1-45.1 of the Code of Virginia, relating to deemed consent to testing and release of test results related to infection with human immunodeficiency virus or hepatitis B or C viruses.

Approved April 2, 1997

[H 2416]

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-45.1 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-45.1. Deemed consent to testing and release of test results related to infection with human immunodeficiency virus or hepatitis B or C viruses.

A. Whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may, according to the then current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus or hepatitis B or C viruses, the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such patient shall also be deemed to have consented to the release of such test results to the person who was exposed. In other than emergency situations, it shall be the responsibility of the health care provider to inform patients of this provision prior to providing them with health care services which create a risk of such exposure.

B. Whenever any patient is directly exposed to body fluids of a health care provider, or of any person employed by or under the direction and control of a health care provider, in a manner which may, according to the then current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus or hepatitis B or C viruses, the person whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such person shall also be deemed to have consented to the release of such test results to the patient who was exposed.

C. For the purposes of this section, "health care provider" means any person, facility or agency licensed or certified to provide care or treatment by the Department of Health, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Rehabilitative Services, or the Department of Social Services, any person licensed or certified by a health regulatory board within the Department of Health Professions except for the Boards of Funeral Directors and Embalmers and Veterinary Medicine or any personal care agency contracting with the Department of Medical Assistance Services.

D. "Health care provider," as defined in subsection C of this section, shall be deemed to include any person who renders emergency care or assistance, without compensation and in good faith, at the scene of an accident, fire, or any life-threatening emergency, or while en route therefrom to any hospital, medical clinic or doctor's office during the period while rendering such emergency care or assistance. The Department of Health shall provide appropriate counseling and opportunity for face-to-face disclosure of any test results to any such person.

E. Whenever any law-enforcement officer is directly exposed to body fluids of a person in a manner which may, according to the then current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus or hepatitis B or C viruses, the person whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such person shall also be deemed to have consented to the release of such test results to the law-enforcement officer who was exposed. In other than emergency situations, it shall be the responsibility of the law-enforcement officer to inform the person of this provision prior to the contact which creates a risk of such exposure.

F. Whenever a person is directly exposed to the body fluids of a law-enforcement officer in a manner which may, according to the then current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus or hepatitis B or C viruses, the law-enforcement officer whose body fluids were involved in the exposure shall be deemed to have consented to testing for

infection with human immunodeficiency virus or hepatitis B or C viruses. The law-enforcement officer shall also be deemed to have consented to the release of such test results to the person.

G. For the purposes of this section, "law-enforcement officer" means a person who is both (i) engaged in his public duty at the time of such exposure and (ii) employed by any sheriff's office, any adult or youth correctional facility, or any state or local law-enforcement agency, or any agency or department under the direction and control of the Commonwealth or any local governing body that employs persons who have law-enforcement authority.

H. If the person whose blood specimen is sought for testing refuses to provide such specimen, any person potentially exposed to the human immunodeficiency virus or hepatitis B or C viruses, or the employer of such person, may petition the general district court of the county or city in which the person whose specimen is sought resides or resided, or, in the case of a nonresident, the county or city where the health care provider or law-enforcement agency has its principal office, for an order requiring the person to provide a blood specimen or to submit to testing and to disclose the test results in accordance with this section. At any hearing before the court, the person whose specimen is sought or his counsel may appear. The court shall be advised by the Commissioner or his designee prior to entering any testing order. If a testing order is issued, both the petitioner and the person from whom the blood specimen is sought shall receive counseling and opportunity for face-to-face disclosure of any test results by a licensed practitioner or trained counselor.

HB 2647

Section 38.2-613:01, NOTIFICATION/REPORTING:

(1997) Expanded HB 1974 to require that insurance applicants, or their designees, be advised of HIV test results.

970562443

HOUSE BILL NO. 2647

Offered January 20, 1997

A BILL to amend the Code of Virginia by adding a section numbered 38.2-613:01, relating to health and life insurance; disclosure of medical test results to insurance applicants.

Patrons—Scott, Brickley, Cunningham, Darner, Davies, Deeds, Grayson, Hall, Hull and Watts; Senators: Barry, Gartlan, Howell, Ticer and Woods

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Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 38.2-613:01 as follows:

§ 38.2-613:01. Disclosure of medical test results to insurance applicants.

Whenever an insurer requires an applicant for life or accident and sickness insurance coverage or for modifications to existing coverage to take an HIV-related test or a test for any other infectious disease, insurers shall advise such applicants, or their designees, of the results of such tests within five business days of the insurer's receipt thereof.

Official Use By Clerks

Passed By The House of Delegates		Passed By The Senate	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

Clerk of the House of Delegates

Clerk of the Senate

HB 2764

Section 22.1-271.3 , NOTIFICATION/REPORTING:

(1997) Required blood-borne pathogen training for all school personnel having direct contact with children, and established a notification procedure in the case of exposure-prone incidents.

CHAPTER 685

An Act to amend and reenact § 22.1-271.3 of the Code of Virginia, relating to public school attendance and school personnel training and certain viral infections; notification of school personnel.

[H 2764]

Approved March 21, 1997

Be it enacted by the General Assembly of Virginia:

1. That § 22.1-271.3 of the Code of Virginia is amended and reenacted as follows:

§ 22.1-271.3. Guidelines for school attendance for children infected with human immunodeficiency virus; school personnel training required; notification of school personnel in certain cases.

A. The Board of Education, in cooperation with the Board of Health, shall develop, and revise as necessary, model guidelines for school attendance for children infected with human immunodeficiency virus. The first such guidelines shall be completed by December 1, 1989. The Board shall distribute copies of these guidelines to each division superintendent and every school board member in the Commonwealth immediately following completion.

B. Each school board shall, by July 1, 1990, adopt guidelines for school attendance for children with human immunodeficiency virus. Such guidelines shall be consistent with the model guidelines for such school attendance developed by the Board of Education.

C. Every school board shall ensure that all school personnel having direct contact with students receive appropriate training in the etiology, prevention, transmission modes, and effects of blood-borne pathogens, specifically, hepatitis B and human immunodeficiency viruses or any other infections that are the subject of regulations promulgated by the Safety and Health Codes Board of the Virginia Occupational Safety and Health Program within the Department of Labor and Industry.

D. Upon request from a school employee who believes he has been involved in a possible exposure-prone incident which may have exposed the employee to the blood or body fluids of a student, the division superintendent shall contact the local health director who, upon immediate investigation of the incident, shall determine if a potentially harmful exposure has occurred and make recommendations, based upon all information available to him, regarding how the employee can reduce any risks from such exposure. The division superintendent shall share these recommendations with the school employee. The division superintendent and the school employee shall not divulge any information provided by the local health director regarding such student. The information provided by the local health director shall be subject to any applicable confidentiality requirements set forth in Chapter 2 (§ 32.1-35 et. seq.) of Title 32.1.

SB 1050

Section 32.1 - 127.1:03, Testing and Counseling

(1997) Expanded public safety testing legislation to include as "employee" and individual providing assistance to public safety personnel, and a victim or witness to a crime.

REENROLLED

CHAPTER 804

An Act to amend and reenact § 32.1-45.2 of the Code of Virginia, relating to testing of certain persons for blood-borne pathogens.

[S 1050]

Approved April 2, 1997

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-45.2 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-45.2. Public safety employees; testing for blood-borne pathogens; procedure available for certain citizens; definitions.

A. If, in the course of employment, an employee of a public safety agency is involved in a possible exposure prone incident, the employee shall immediately, or as soon thereafter as practicable, notify the agency of the incident in accordance with the agency's procedures for reporting workplace accidents.

B. If, after reviewing the facts of the possible exposure prone incident with the employee and after medical consultation, the agency concludes that it is reasonable to believe that an exposure prone incident may have occurred, (i) the agency shall request the person whose body fluids were involved to give informed consent, as provided in § 32.1-37.2, to submit to testing for hepatitis B *or C* virus and human immunodeficiency virus and to authorize disclosure of the test results or (ii) if the person is deceased, the agency shall request the custodian of the remains to preserve a specimen of blood and shall request the decedent's next of kin to provide informed consent, as provided in § 32.1-37.2, to such testing and to authorize disclosure of the test results.

C. If a person is involved in a possible exposure prone incident involving the body fluids of an employee of a public safety agency, the person may request the agency to review the facts of the possible exposure prone incident for purposes of obtaining the employee's informed consent, as provided in § 32.1-37.2, to test for hepatitis B *or C* virus and human immunodeficiency virus and to authorize disclosure of the test results. If, after reviewing the facts and after medical consultation, the agency concludes it is reasonable to believe an exposure prone incident involving the person and the employee may have occurred, (i) the agency shall request the employee whose body fluids were involved to give informed consent to submit to testing for hepatitis B *or C* virus and human immunodeficiency virus and to authorize disclosure of the test results or (ii) if the employee is deceased, the agency shall request the custodian of the remains to preserve a specimen of blood and shall request the decedent's next of kin to provide informed consent, as provided in § 32.1-37.2, to such testing and to authorize disclosure of the test results.

D. If informed consent is refused under subsection B of this section, the public safety agency or the employee may petition the general district court of the city or county in which the person resides or resided, or in the case of a nonresident, the city or county of the public safety agency's principal office, to determine whether an exposure prone incident has occurred and to order testing and disclosure of the test results.

If informed consent is refused under subsection C of this section, the person involved in the possible exposure prone incident may petition the general district court of the city or county of the public safety agency's principal office to determine whether an exposure prone incident has occurred and to order testing and disclosure of the test results.

E. If the court finds by a preponderance of the evidence that an exposure prone incident has occurred, it shall order testing for hepatitis B *or C* virus and human immunodeficiency virus and disclosure of the test results. The court shall be advised by the Commissioner or his designee in making this finding. The hearing shall be held in camera as soon as practicable after the petition is filed. The record shall be sealed.

F. A party may appeal an order of the general district court to the circuit court of the same jurisdiction within ten days from the date of the order. Any such appeal shall be de novo, in camera, and shall be heard as soon as possible by the circuit court. The circuit court shall be advised by the Commissioner or his designee. The record shall be sealed. The order of the circuit court shall be final

and nonappealable.

G. Disclosure of any test results provided by this section shall be made to the district health director of the jurisdiction in which the petition was brought or the district in which the person or employee was tested. The district health director or his designee shall inform the parties of the test results and counsel them in accordance with subsection B of § 32.1-37.2.

H. The results of the tests shall be confidential as provided in § 32.1-36.1.

I. No person known or suspected to be positive for infection with hepatitis B *or C* virus or human immunodeficiency virus shall be refused services for that reason by any public safety agency personnel.

J. For the purpose of this section and for no other purpose, the term "employee" shall include: (i) any person providing assistance to a person employed by a public safety agency who is directly affected by a possible exposure prone incident as a result of the specific crime or specific circumstances involved in the assistance and (ii) any victim of or witness to a crime who is directly affected by a possible exposure prone incident as a result of the specific crime.

K. This section shall not be deemed to create any duty on the part of any person where none exists otherwise, and a cause of action shall not arise from any failure to request consent or to consent to testing under this section. The remedies available under this section shall be exclusive.

~~J.~~ *L.* For the purposes of this section, the following terms shall apply:

"Exposure prone incident" means a direct exposure to body fluids of another person in a manner which may, according to the then current guidelines of the Centers for Disease Control, transmit hepatitis B *or C* virus or human immunodeficiency virus and which occurred during the commission of a criminal act, during the performance of emergency procedures, care or assistance, or in the course of public safety or law-enforcement duties.

"Public safety agency" means any sheriff's office and any adult or youth correctional, law-enforcement, fire safety organization or any agency or department that employs persons who have law-enforcement authority and which is under the direction and control of the Commonwealth or any local governing body.

HB 673

Duty to Protect Third Parties; Immunity

CHAPTER 958

An Act to amend the Code of Virginia by adding a section numbered 54.1-2403.2, relati to mental health service providers; duty to protect third parties; immunity.

[H 6

Approved May 20, 1994

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 54.1-2403.2 follows:

§ 54.1-2403.2. Mental health service providers; duty to protect third parties; immunity

A. As used in this section:

"Certified substance abuse counselor" means a person certified to provide substan abuse counseling in a state-approved public or private substance abuse program facility.

"Client" or "patient" means any person who is voluntarily or involuntarily receivi mental health services or substance abuse services from any mental health servi provider.

"Clinical psychologist" means a person who practices clinical psychology as defined § 54.1-3600.

"Clinical social worker" means a person who practices social work as defined in 54.1-3700.

"Licensed practical nurse" means a person licensed to practice practical nursing defined in § 54.1-3000.

"Mental health professional" means a person who by education and experience professionally qualified and licensed in Virginia to provide counseling interventio designed to facilitate an individual's achievement of human development goals a remediate mental, emotional, or behavioral disorders and associated distresses whi interfere with mental health and development.

"Mental health service provider" or "provider" refers to any of the following: (i) person who provides professional services as a certified substance abuse counselor, clinic psychologist, clinical social worker, licensed practical nurse, mental health profession physician, professional counselor, psychologist, registered nurse, school psychologist, social worker; (ii) a professional corporation, all of whose shareholders or members are licensed; or (iii) a partnership, all of whose partners are so licensed.

"Professional counselor" means a person who practices counseling as defined in 54.1-3500.

"Psychologist" means a person who practices psychology as defined in § 54.1-3600.

"Registered nurse" means a person licensed to practice professional nursing as defin in § 54.1-3000.

"School psychologist" means a person who practices school psychology as defined in 54.1-3600.

"Social worker" means a person who practices social work as defined in § 54.1-3600.

B. A mental health service provider has a duty to take precautions to protect thi parties from violent behavior or other serious harm only when the client has orally, writing, or via sign language, communicated to the provider a specific and immedic threat to cause serious bodily injury or death to an identified or readily identifiable pers or persons, if the provider reasonably believes, or should believe according to t standards of his profession, that the client has the intent and ability to carry out th threat immediately or imminently. If the third party is a child, in addition to taki precautions to protect the child from the behaviors in the above types of threats, t provider also has a duty to take precautions to protect the child if the client threatens engage in behaviors that would constitute physical abuse or sexual abuse as defined in 18.2-67.10. The duty to protect does not attach unless the threat has been communicat to the provider by the threatening client while the provider is engaged in his professior duties.

C. The duty set forth in subsection B is discharged by a mental health service provid who takes one or more of the following actions:

1. Seeks civil commitment of the client under Chapter 2 (§ 37.1-63 et seq.) of Title 37

2. Makes reasonable attempts to warn the potential victims or the parent or guardi of the potential victim if the potential victim is under the age of eighteen.

3. Makes reasonable efforts to notify a law-enforcement official having jurisdiction in the client's or potential victim's place of residence or place of work, or place of work of the parent or guardian if the potential victim is under age eighteen, or both.

4. Takes steps reasonably available to the provider to prevent the client from using physical violence or other means of harm to others until the appropriate law-enforcement agency can be summoned and takes custody of the client.

5. Provides therapy or counseling to the client or patient in the session in which the threat has been communicated until the mental health service provider reasonably believes that the client no longer has the intent or the ability to carry out the threat.

D. A mental health service provider shall not be held civilly liable to any person for:

1. Breaching confidentiality with the limited purpose of protecting third parties by communicating the threats described in subsection B made by his clients to potential third party victims or law-enforcement agencies or by taking any of the actions specified in subsection C.

2. Failing to predict, in the absence of a threat described in subsection B, that the client would cause the third party serious physical harm.

3. Failing to take precautions other than those enumerated in subsection C to protect a potential third party victim from the client's violent behavior.

DUTY TO TAKE PRECAUTIONS

Definitions

"***Client***" or "***patient***" means any person who is voluntarily or involuntarily receiving mental health services or substance abuse services from any mental health service provider.

"***Mental health service provider***" or "***provider***" refers to any of the following: (i) a person who provides professional services as a certified substance abuse counselor, clinical psychologist, clinical social worker, **licensed practical nurse**, mental health professional, **physician**, professional counselor, psychologist, **registered nurse**, school psychologist, or social worker; (ii) a professional corporation, all of whose shareholders or members are so licensed; or (iii) a partnership, all of whose partners are so licensed.

DUTY TO TAKE PRECAUTIONS

When Duty Arises

1. There must be communication--

   orally or

   in writing or

   through sign language

2. To the provider (as defined)

3. Of a threat to cause serious bodily injury or death;

4. The threat must be specific;

5. The threat must be immediate;

6. The target of the serious bodily injury or death must be identified or readily identifiable person or persons;

7. The provider must reasonably believe, or should believe according to the standards of the profession

8. That the threatening patient has--

   the intent to carry out the threat and

   the ability to carry out the threat.

DUTY TO TAKE PRECAUTIONS

Discharge of the Duty

1. Provider seeks civil commitment under Va. Code §§ 37.1-63 *et seq.*;
2. Provider makes reasonable attempts to warn potential victim or victims;
3. Provider makes reasonable efforts to notify a law-enforcement official having jurisdiction in--

   the patient's place of residence or work or

   the potential victim's place of residence or work;
4. Provider takes steps reasonably available to prevent the patient from using physical violence or other means of harm to others until the appropriate law-enforcement agency can be summoned and takes custody of the patient;
5. Provider provides therapy or counseling to the patient in the session in which the threat has been communicated until the provider reasonably believes the client no longer has the intent or ability to carry out the threat.

DUTY TO TAKE PRECAUTIONS

Liability

1. No liability of breaching confidentiality with the limited purpose of protecting third parties by communicating the threats described as "when duty arises"--

   To potential third-party victims or

   Law enforcement agencies or

   By taking any of the actions described as "discharge of the duty";

2. No liability for failing to predict, in the absence of a threat described as "when duty arises," that the patient would cause the third party serious physical harm;

3. No liability for failing to take precautions other than those enumerated in "discharge of the duty" to protect a potential third-party victim from the patient's behavior.

Security & Confidentiality Guidelines

for

Employees

COMMONWEALTH OF VIRGINIA
Virginia Department of Health
Division of HIV/STD
1500 East Main Street
P.O. Box 2448, Room 112
Richmond, Virginia 23218-2448

Security and Confidentiality Guidelines

Certificate of Receipt

Your signature below indicates your receipt of the Division of HIV/STD *Security and Confidentiality Guidelines*, including but not limited to:

- The Division of HIV/STD Confidentiality Statement
- The Division of HIV/STD Statement of Employee Responsibility
- The Division of HIV/STD Statement of Conflict of Interest

[ ] *Check here if a potential conflict of interest exists. All employees must complete the section regarding the Statement of Conflict of Interest*

Your signature does not imply agreement or disagreement with the guidelines; however, all employees are required to comply with the Division of HIV/STD Security and Confidentiality Guidelines.

Name *(print)*:_____

Signature:_____ Date:_____

Supervisor's Signature:_____ Date:_____

CC: Employee
Supervisor
File

Revised 2/21/01

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Virginia Department of Health - Division of HIV/STD
Security and Confidentiality Guidelines

Virginia Department of Health
Division of HIV/STD
Security and Confidentiality Guidelines

Preface

The Division of HIV/STD is located in Richmond, Virginia, and along with seven other divisions, provides the framework for the Virginia Department of Health (VDH) Office of Epidemiology.

The mission of the Division of HIV/STD is to support health districts/departments and non-governmental organizations in the prevention and treatment of HIV and other STDs, including their complications, through provisions of education, information and health care services that promote and protect the health of all Virginians.

The collection, entry and analysis of HIV/AIDS and other STD data are principle functions used to shape Division surveillance and prevention activities. The following documentation serves as the official policy and procedural guidance for Division of HIV/STD confidentiality and security pertaining to all HIV/AIDS and STD data. Due to the importance and sensitive nature of the Division's confidential documentation, a variety of security issues are repeated throughout these guidelines.

I. Background: Regulatory and Division Documentation

State Reporting Regulations:
Regulations pertaining to disease reporting within the Commonwealth of Virginia are listed in the State Board of Health's *Regulations for Disease Reporting and Control*. Relevant sections of the *Code of Virginia* pertaining to the Division of HIV/STD include:

Confidentiality §§ 32.1—38, 32.1-41, 32.1-71, and 32.1-71.4
Reportable Disease List 12 VAC 5-90-80
Those Required to Report 12 VAC 5-90-90

Division Documentation:
Overall Responsible Party:
The Director of the Division of HIV/STD serves as the Overall Responsible Party (ORP) for all Division activities, including the security and confidentiality of HIV/AIDS and other STD data. The ORP signs documentation pertaining to the HIV/AIDS Surveillance grant on a yearly basis, certifying appropriate handling and maintenance of security measures.

The Division of HIV/STD requires signed documentation, utilizing the enclosed Certificate of Receipt for newly hired employees and renewed signatures on an annual basis for existing employees, for the purpose of ensuring relevant personnel are initially informed and remain familiar with Division policy pertaining to the security and confidentiality of sensitive data. The text of this document addresses issues such as confidentiality, conflicts of interest, Division policies, alcohol/ drugs (state policy), employee responsibility and information systems security/access. As an added security precaution, Division supervisors are required to complete Division employment, and policy and procedure checklists for each employee. The original signed copy of the Certificate of Receipt is kept in the employee's personnel files. Signed copies are maintained by the supervisor and also provided to the employee for his/her personal records.

The Division's policies and procedures, including the Security and Confidentiality Guidelines, are thoroughly documented in the HIV/STD Manual. Copies of this manual are distributed to Division and pertinent local health department staff.

Certificate of Receipt:
The Certificate of Receipt serves as the official Division documentation pertaining to employee knowledge of Division Security and Confidentiality Guidelines. With the exception of potential conflicts of interest, this certificate shall suffice as the only Division-specific documentation requiring signature. It shall be updated annually.

By signing the Certificate of Receipt, the employee acknowledges an understanding of the confidentiality policies of the Division of HIV/STD and agrees to abide by such policies throughout the course of employment with the Division. In addition, the employee acknowledges that the regulations governing the confidentiality and disclosure

of information related to HIV/STD are mandated by the *Code of Virginia* and that the regulations are therefore not necessarily limited to current employees of the Division.

Employment Checklist :
The Employment Checklist was created for managerial and supervisory use to ensure specific issues are addressed and completed during initial employment as well as upon termination, including issues such as email, LAN accounts and ID cards. This checklist does not require signatures but should be maintained in both the supervisor's and the official personnel files (see attachment). Additional spaces are provided for supervisor use in the event items not listed on the checklist need to be included.

Statement of Confidentiality:
All persons working in the Division of HIV/STD are required to maintain and protect confidential records and related documents. To ensure that all Division personnel understand and are aware of the responsibilities of maintaining confidentiality, they are provided this synopsis of confidentiality requirements to read and understand. This policy applies to any person performing work for, or in conjunction or collaboration with, the Division of HIV/STD, including classified, contract, wage and temporary employees. All persons must comply with the following procedures.

Physical Security of Records
All records within the Division are confidential, including personnel records and patient files, both paper and electronic. Only authorized personnel may receive or review confidential documents, and only authorized personnel may enter record storage areas. No confidential information shall be released to individual(s) not granted access by the ORP. Confidential information shall be accessed only by a staff member with the authority to access such information, as delegated to individual employees by the supervisor, and with an expressed need to access such information. The employee shall exercise good judgment regarding access to information. All confidential information shall be used in accordance with the employee's job assignments.

Any confidential communication (written, verbal or electronic) shall be shared with other persons on a strict need to know basis. Confidential information shall be shared with an authorized individual as designated in Sections 32.1-36.1.A, 32.1-38 and 32.1.41 of the *Code of Virginia* only when an expressed need to receive such information is confirmed. The employee shall exercise good judgment regarding the sharing of information.

Confidential information (case reports, databases, line lists, computers, any records with identifying information in written, electronic or other format) shall only be removed from the office of the Division of HIV/STD for the expressed purpose of conducting the official business of the Division at the direction of the employee's supervisor. All confidential information mailed from the offices of the Division of HIV/STD shall be marked *CONFIDENTIAL, TO BE OPENED BY ADDRESSEE ONLY* and *FIRST CLASS.*

Confidential information shall be mailed in a manner that does not allow information to be revealed without opening the envelope (fold names to the inside) and envelopes shall be taped shut to ensure security. All confidential information carried outside the offices of the Division of HIV/STD shall be appropriately safeguarded and shall remain the responsibility of the employee until such information is delivered or returned to Division offices.

All documents containing patient identifiers shall be secured in a locked file cabinet or drawer at the end of the business day. All documents with identifying information that are no longer needed shall be shredded.

Disclosure

Confidential information should not be given out over the telephone without first confirming that the recipient is allowed access to this information. Confidential information shall not be left over voice mail. Confidential information shall be faxed WITH CAUTION. Confidential information shall not be transmitted via e-mail.

All subpoenas and other legal papers requesting the disclosure of confidential information served to any work unit within the Division shall be referred to the Division Director for consultation with the Attorney General's Office.

Patient level data collected under Section 32.1.-36.1 of the *Code of Virginia* shall be exempt from the provision of the Virginia Freedom of Information Act. This information is considered confidential. "No report published by *[a]* nonprofit organization, the Commissioner, or other person may present information that reasonably could be expected to reveal the identity of any patient. Publicly available information shall be designed to prevent persons from being able to gain access to combinations of patient characteristic data elements that reasonably could be expected to reveal the identity of any patient." (*Code of Virginia,* Section 32.1.-276.9). Release of any statistical information shall follow the "Rule of Three," as described on page 14.

Electronic Security

All logon IDs and passwords shall be safeguarded, and passwords shall not be revealed to others. Always exit any confidential databases when not in use. Employees are responsible for all activities performed under their assigned logon ID. If the system is misused under an employee's password, the employee is responsible. Access to databases on computers, including laptops, shall be password protected. Passwords shall be changed routinely.

Do not print materials with identifying information on general use or unprotected printers. Do not send confidential information via e-mail. E-mail is not secure and may be seen by more people than the intended recipient. When faxing confidential material, notify the intended recipient immediately prior to sending the information. Remove disease identifiers prior to faxing.

Custom databases and files with name identifiers on individual workstations, laptop computers and diskettes shall be deleted immediately upon completion of projects requiring this information. Data shall be deleted from computers before they are reassigned or designated as surplus.

WHEN IN DOUBT, ASK YOUR SUPERVISOR FOR GUIDANCE BEFORE SHARING INFORMATION.

Consequences
Violations of confidentiality and disclosure policies are subject to disciplinary action set forth in the Standards of Conduct and Performance and/or prosecution under the law as set forth in the *Code of Virginia*, Chapter 2, Title 32.1 and other applicable regulations.

Statement of Conflict of Interest:
As an employee of the Division of HIV/ STD, you may handle or have access to information that is confidential or not routinely available to the general public. According to the Virginia Conflict of Interest Act, you cannot pass on information to which you have access in your job, nor use it for personal gain or benefit.

Under the Virginia Conflict of Interest Act, Article 2, Section 2.1-639.4: You may not receive outside compensation for work done as part of your official duties. You may not receive compensation for use of your public position or knowledge gained as a public employee to obtain a contract for a person or business with a government agency. You may not benefit from confidential information or information that is not publicly available. You may not receive compensation, services or business or professional opportunities that may reasonably tend to influence you in the performance of your official duties.

The Division of HIV/STD contracts with outside organizations to perform activities such as HIV prevention and education in the community. It is the policy of the Division that employees, who participate as members of organizations receiving funds from the Division, may not serve as members of the Board of Directors or other governing body or as officers in such organizations during the funding period(s). Refer to the *Code of Virginia*, Article 3, section 2.1-639.6 for additional prohibitions regarding contracts.

Employment activities outside of regular working hours requires the approval of the agency to assure no violations of the Conflict of Interest Act occur. Employees desiring outside employment should submit an "Outside Employment Form" prior to beginning outside employment (Department of Health Policy Rule No. 9.5).

Federal law limits the political activities of governmental employees. If your position is federally funded, you are prohibited from running for public elected office as a partisan candidate. No employee may campaign for themselves or others during working hours (Employee Handbook 1992-95, pp. 37-38).

Violations of the Virginia Conflict of Interest Act will lead to disciplinary action as set forth in the Standards of Conduct and Performance and/or prosecution under law.

_____ I currently have no potential conflict of interest. I understand the policies as set forth above and agree to inform my supervisor in the event a potential conflict of interest arises.

_____ I am a member of the following organization that may potentially receive funds from the Division of HIV/STD: _____. This organization does not currently receive funding from the Division of HIV/STD. I understand that I may hold a position of authority within this organization as long as the organization receives no funding from the Division of HIV/STD, but in the event that this organization is awarded funding from the Division, I would be required to resign such a position immediately to avoid a potential conflict of interest.

_____ I am a member of the following organization that receives funds from the Division of HIV/STD: _____. I am not a member of the Board of Directors or other governing body nor am I an officer in this organization. I understand that as long as this organization receives funds from the Division of HIV/STD, I am prohibited from holding any such position.

_____ I am a member of the following organization that receives funds from the Division of HIV/STD: _____ and I hold the following position of authority in this organization: _____. In order to avoid a potential conflict of interest, I agree to resign from the above stated position. I understand that as long as this organization receives funds from the Division of HIV/STD, I am prohibited from holding any such position.

Statement of Employee Responsibility:

All employees of the Division of HIV/STD are individually responsible for state property directly issued to them during the course of employment. Such property may consist of state identification cards, building access cards, parking permits, cell phones, pagers, etc. Specific computer hardware and software are also the responsibility of the employee to whom the equipment is provided. These items are state property and must be returned to the Division upon request or termination of employment.

The state identification cards and building access cards are for use by the designated employee only. The employee shall not allow any unauthorized use of either of these cards. It is the employee's responsibility to immediately notify their supervisor in the event either of these cards become misplaced or lost. Upon resignation or termination of employment, the employee shall return both the state identification card and the building access card to their immediate supervisor.

Parking permits are available to classified, wage and contractual employees. Classified employees who elect to contract for this parking can have the monthly fee subtracted from their paycheck via payroll deduction or pay by check or cash on a monthly basis. Wage and contractual employees do not have the option of payroll deduction; monthly fees must be paid in advance to the parking coordinator each month. Failure to pay the parking fee will terminate the employee's parking contract. It is the employee's responsibility to cover any costs related to the loss of the parking permit or the failure to return the permit to their immediate supervisor upon termination of employment. Any outstanding balance not paid in a prompt manner will be turned over to the Department's collection agency.

Computers, peripheral equipment and software shall not be removed from the Division of HIV/STD, for any reason, without prior supervisory approval. Any computer or peripheral equipment designated as check-out equipment that is removed from the premises shall be documented on the PC Equipment Logout Calendar.

All equipment such as copiers, fax machines, telephones, pagers and computers (including e-mail) are for official state use only. Any misuse related to these items will be dealt with on an individual basis.

In addition to the above issues, each employee is individually responsible for the following: 1) maintaining confidentiality of all division data and information; 2) ensuring clearance of all issues that may pose a conflict of interest; and 3) ensuring compliance with the Commonwealth of Virginia's Policy on Alcohol and Other Drugs.

Division Policies & Procedures Checklist:
This checklist serves to ensure that pertinent issues have been fully addressed and understood by newly hired employees. It includes a review of issues such as confidentiality, break/lunch schedules, smoking policies, etc. The original copy of this completed form is kept in the Division's official personnel files. Copies are maintained by the supervisor and employee.

Equipment Logout Form/Calendar:
Equipment such as laptop computers as well as LCD projectors may be checked out for official work-related activities. Equipment checked out by Division staff are monitored by the HRDP User Liaison. The logout form/calendar for acquiring such equipment is located within the HRDPs office. The recipient is required to record the specific equipment to be used, expected date of return and his/her initials. Upon return of the equipment, the borrower initials the form/calendar on the day the equipment was returned.

II. PHYSICAL SECURITY

Building Access

The Virginia Department of Health is currently housed at Main Street Station (MSS), 1500 East Main Street, Richmond, Virginia. Building access is monitored via an employee entry card system. The access card can be used at any time of the day and must be used to enter the building at all entrances except the main VDH entrance at Franklin Street. This entrance is open to the public during normal business hours and is accessible via the access card system after hours.

Employee Identification (ID) Badges

All VDH employees have been provided identification badges. This ID includes a color photo image of the employee, as well as the employee's signature.

Division of HIV/STD

Office Accessibility

The Division of HIV/STD is currently housed in 8 office locations within MSS. Division offices which involve work-related activities using personally identifiable information are deemed confidential areas and are locked during non-business hours. Access to these areas during working hours is limited to those employees whose positions require such accessibility. Keys to these rooms are also limited to only a few individuals. Non-Division staff and any other unknown individuals are questioned upon entrance to any of these rooms by the first Division employee who identifies the person attempting to enter a secure area. Signs are also posted at the entrances to these rooms stating that no unauthorized individuals are allowed.

Two additional keys to the secure room used by the HIV/AIDS Surveillance Program are maintained by the HIV/AIDS Program Coordinator. These keys are checked out by surveillance consultants or other staff when such individuals request to perform work outside of regular business hours. With supervisory approval, such keys may be checked out for a specified date. The HIV/AIDS Program Coordinator monitors this process and ensures keys are returned appropriately.

Cleaning crews can not access confidential areas outside of regular business hours. All cleaning and regular maintenance is performed between the hours of 8am-5pm.

File Room Accessibility

The Division of HIV/STD file room is a secure room enclosed within a larger access-controlled office. The file room is equipped with an electronic monitoring system that records the user, date and time of file room access. This system requires that users have a unique pass code. When the alarm sounds, the monitoring site calls a specified phone number (HIV/AIDS Program Coordinator) within the Division. If the person on the phone can not provide the appropriate information, police are dispatched to the scene. The Director of Statistics & Data Management records all such instances and serves as

the liaison between the Division and the security firm responsible for monitoring the system.

File Cabinet Accessibility
All filing cabinets used by staff handling confidential data shall be equipped with bar locks, in addition to any pre-existing locking mechanism. Any confidential information being worked that is not immediately returned to the file room or does not reside in the file room, i.e. ADAP data, is locked within these filing cabinets at the end of each workday. Keys to the filing cabinets are maintained by the individual employees. A spare key is always maintained by the office manager.

III. COMPUTER SECURITY

Each employee is responsible for protecting his or her own workstation and laptop, if applicable, regarding confidential information. This responsibility also includes the protection of office door keys, file cabinet/desk keys, diskettes and passwords/codes that would allow access to confidential information or data. All data-related papers and diskettes must be stored appropriately when staff are away from their work areas. This includes proper filing at the end of a workday and appropriate precautions for short durations during work hours. Each employee must exercise necessary precautions not to infect data-related software with computer viruses and not to expose hardware to extreme temperature variations.

The Division of HIV/STD HRDP User Liaison maintains an inventory of all computer-related equipment. All accessories are logged as well as to whom equipment has been assigned.

Network Accessibility
The Division of HIV/STD uses Novell 5.0 for its local area network operations. All confidential databases are stored on the network; however, user rights to such files have been limited to, and such files can only be seen by, required staff. All network users have unique passwords that require forced changes every 40 days. Intruder lockouts occur once an incorrect password has been attempted several times. Only the system administrator (HRDP User Liaison, HRDP User Liaison back up or the Director of Statistics & Data Management) can reset the user's account. With a few exceptions, user accounts are limited to 1 login at a time. This helps to control PCs being left connected to the network inadvertently, thus decreasing likelihood of unauthorized access.

Passwords for required network processes are maintained in writing by the Director of Statistics and Data Management in an undisclosed location, known only by the above individual, the HRDP User Liaison and the HRDP back up technician. These passwords are contained in a sealed envelope, signed by the Director of Statistics and Data Management across the seal and taped shut. In the event any of the three above staff members terminate employment with the Division of HIV/STD, or if the envelope is

considered to have been tampered, the passwords and the location of the envelope are immediately changed. Any changes to network user accounts and/or associated user rights must be approved by the Director of Statistics and Data Management. Maintenance of user accounts is performed by the HRDP User Liaison.

Database Accessibility

Confidential databases used by the Division of HIV/STD are maintained solely on the Network. All such database files are structured with rights limited to staff whose job requires such access. Within STD*MIS, individual user accounts and rights are set up and maintained by the Central Registry Unit (CRU) supervisor. User accounts and rights within HARS are maintained by the Statistical Analyst, Senior in charge of HARS reports and analysis. Any changes to user accounts and/or associated user rights must be approved by the Director of Statistics and Data Management.

Currently, the Division is working with CDC on a pilot program to access HARS database information remotely. All such access shall be performed within the limits of the pilot project.

PC Workstation Accessibility

All PCs within the Division of HIV/STD are required to be turned off at the end of each workday. Staff with PCs that access confidential information shall ensure that such databases are closed and/or the PCs are turned off when leaving the work area for periods of time such as lunch breaks. When PCs are left unattended for short durations such as bathroom breaks, monitors should be turned off to reflect a blank screen.

All Division staff are required to report any suspicious activity involving their PC immediately to their supervisor. In such instances, Division management may decide to include a BIOS password on the PC as an added security precaution.

Any PC in a non-secure location used to access or utilize confidential information shall be protected by a BIOS password. Also, database access shall only be performed while physically located at the PC. Any absence from the PC, such as bathroom breaks, requires that the database be completely closed; turning off the monitor is unacceptable in such locations. The PC monitor must also be situated such that it can not be easily viewed by persons other than the user.

PC-related Surplus, Redistribution and Disposal

Any PC-related equipment, i.e. desktops, laptops, servers, etc. tagged for state surplus or redistribution shall first be reviewed by the HRDP User Liaison to ensure confidential data is absent from the hard drive. All such equipment shall be cleared of any potential confidential information using Norton WipeInfo®. Server hard drives shall be removed from surplus items and retained by the Division of HIV/STD. Such items shall be stored in the electronic file room for added security. Desktop PCs are either stripped of their

hard drives or have a low level format performed using Novell. If a desktop PC is being redistributed to other staff within the Division, a check is performed to ensure confidential data is absent from the machine. Diskettes used to store confidential information for a specific task shall be cleared of all potential data immediately after completion of the task using Norton WipeInfo®. When disposing of a $3^1/_2$" diskette, the sliding metal cover must be removed from the diskette. An object such as a letter opener or pen/pencil must be used to punch a hole through the data sleeve inside the plastic casing. Scissors or a shredder must be used to destroy old $5^1/_4$" floppy diskettes.

IV. DATA-RELATED SECURITY AND CONFIDENTIALITY

Authorized Data & Database Usage
User accounts for confidential databases are maintained by specified staff and supervised by the Director of Statistics and Data Management. Network access to specified databases is maintained by the HRDP User Liaison (see Database Accessibility section on page 9). Access to confidential surveillance information is limited to staff who require such information to perform their work activities. User accounts are deleted immediately upon termination of an employee's need to access a confidential database system.

Authorized access to confidential areas/databases are as follows:

Electronic File Room
Director, Division of HIV/STD
Director of Statistics & Data Management
HIV/AIDS Surveillance Coordinator
HIV/AIDS Epidemiology Consultants (4)
HIV/AIDS Pediatric Coordinator
HIV/AIDS and HIV1 Counseling and Testing Clerk
Statistical Analyst, Sr.'s (2)
Statistical Analysts (2)
CRU Data Entry Operators (2)
HRDP User Liaison

HIV/AIDS Reporting System (HARS)
Director of Statistics & Data Management
HRDP User Liaison
Statistical Analyst, Sr.'s (2)
Statistical Analysts (2)
HIV/AIDS Surveillance Coordinator
HIV/AIDS Epidemiology Consultants (4)
HIV/AIDS Pediatric Coordinator

*Sexually Transmitted Disease Management Information System (STD*MIS)*
Director of Statistics & Data Management
HRDP User Liaison
Statistical Staff:
- Statistical Analyst, Sr.'s (2)
- Statistical Analysts (2)

Central Registry Unit (CRU) Staff:
- CRU Supervisor
- CRU Front Line Supervisor
- Office Support Staff/Data Entry Operators (3-4)

Chlamydia Infertility Screening Program
- Office Support Staff/Data Entry Operators (3)

Syphilis Elimination Project:
- Public Health Advisor
- Syphilis Elimination Coordinator

HIV/AIDS Surveillance Staff:
- HIV/AIDS Surveillance Coordinator
- HIV/AIDS Epidemiology Consultants (4)
- HIV/AIDS Pediatric Coordinator

Viral Hepatitis Program Staff:
- Viral Hepatitis Surveillance Consultant
- Office Support/Data Entry Operator

HIV1 Counseling and Testing Database
Director of Statistics & Data Management
HRDP User Liaison
HIV- Counseling and Testing Coordinator
Statistical Staff:
- Statistical Analyst, Sr.'s (2)
- Statistical Analysts (2)

HIV-1 Data Entry Operators (2-3)

Personnel outside the Division's confidential units may gain access to confidential information only if 1) the request for such information has been authorized by the ORP and is deemed a justifiable public health need, and 2) the request does not compromise or impede surveillance or other confidential Division activities.

Identifying information from Division databases shall be shared with other disease registries only after a thorough review by the ORP. The ORP will limit such activities to other registries that can demonstrate a justifiable need for the data. The decision to allow such activity will also be weighed against the benefits and risks of allowing access and upon certification that the level of security established by the other registry is at least equivalent to the standards described in this document. The final decision regarding the sharing of registry data and data matches rests upon the ORP.

Photocopying and Printing of Confidential HIV/AIDS/STD Surveillance Data
Employees shall not print materials with identifying information on general use or non-secure printers. All printing of such documentation shall occur within the confines of a secure office and the print job shall be removed from the printer immediately upon completion. Any unnecessary copies shall be shredded immediately, as well as originals once its use is obsolete.

Photocopying of confidential information should occur only within the confines of a secure office and should be removed from the photocopier immediately upon completion. Only the mandatory number of copies of such information shall be photocopied. Any extra or test copies shall be shredded immediately upon completion.

Retention of Hard Copy Files
All morbidity records, interview records and field records are retained for surveillance-related and historical purposes. The ORP makes all final decisions regarding the retention of such records. All records related to HIV/AIDS are stored within a locked file room that is monitored by a security firm 24 hours a day. Only authorized employees have access to this room. Employee access is reviewed by the Director of Statistics and Data Management via security reports on a weekly basis. Other STD data are boxed at year-end and stored in a secure location. Only authorized employees may review such records.

HARS Back-ups of HIV/AIDS Surveillance Data
The HARS surveillance database is backed up on a daily basis via two separate back-up systems. Firstly, statistical staff perform a manual back-up of HARS data at the end of every work day using diskettes. Once the daily back up is performed, these diskettes are stored inside the locked file room. Once diskettes have been used repeatedly, they are replaced and the old diskettes are disassembled, cut up and discarded. The second data back up is performed automatically through the Local Area Network (LAN). This back up includes all databases plus other relevant Division information. A series of back up tapes exists that allow a 4 week circulation of off-site storage. Each Monday, a back up tape is provided to the Office of Information Management (OIM) for off-site storage. Each week, the tape back up which has been at off-site storage the longest is returned to OIM and the tape is placed back in the Division's circulation. All Virginia Department of Health back up tapes are handled by an off-site storage company and transferred to and from their facility within a locked case. The tape back up system and LAN servers are located within an OIM secured area. Only authorized personnel may access this area.

Data Transfers
CDC – Data transfers to CDC, minus personal identifiers, are performed via email, with the approval of the ORP. All transferred data encompasses only the fields needed to ensure compliance with CDC data requirements. HIV/AIDS (HARS) data transfers are conducted twice monthly by the Director of Statistics & Data Management. Data

transfers for HIV Counseling and Testing (CTS) are performed monthly by the Statistical Analyst, Sr. in charge of the CTS database. Both of these transfers are sent directly to designated CDC personnel. The Division of HIV/STD National Electronic Telecommunications System for Surveillance (NETSS) data transfers are prepared weekly by the CRU Supervisor and provided to the Division of Surveillance and Investigation for inclusion with the statewide NETSS transfer.

Contractors – Data transfers to or from contractors are only performed via email if personal identifiers are nonexistent. Any data including personal identifiers approved for analysis by a contractor are hand-delivered without easily identifiable disease information, if possible. Hard copy data transfers including personal identifiers should not include identifiable disease information and should be hand-delivered to applicable personnel inside envelopes without specific indication of the nature of the data. All Division of HIV/STD data managed by contractors are subject to all guidelines within this document. Any dissemination of information resulting from data managed by contractors shall be reviewed by Division of HIV/STD staff prior to release. Sufficient time should be allotted for this review procedure. A copy of all final products shall be provided to the Division at the time of dissemination. All contractors shall sign applicable Division of HIV/STD protocols regarding data releases and confidentiality on an annual basis.

Other VDH Offices – No data including personal identifiers shall be transferred or shared with other VDH Offices or Divisions unless approved by the ORP. However, applicable information, record searches, etc for local health department STD personnel may be released, although confirmation of the requestor and/or location shall be performed. Any uncertainties regarding the release of information to local health department staff shall be reviewed with supervisors. Any other VDH Office or Division which receives confidential data from the Division of HIV/STD shall sign applicable Division of HIV/STD policies regarding data release and confidentiality.

Retention/Disposal of HIV/AIDS/STD Surveillance Data

Any data generated that includes personally identifiable information shall be retained within applicable work areas and used solely for the purpose of official Division business. Data with personal identifiers needed for historical purposes shall be stored in locked areas. Personally identifiable data generated through Division databases, spreadsheets, etc. that are no longer needed shall be immediately shredded prior to disposal. Computer files including personal identifiers shall only be stored on the Division network in designated folder locations. No personally identifiable data files should be stored on individual PC hard drives. Such files may be stored on a secure area PC hard drive for particular work-related purposes; however, these files should be deleted immediately upon completion of the project.

Release of Data to Non-Division Personnel

Division data may only be released to non-Division personnel after a signed and completed data request and signed data recipient agreement has been submitted to the Division (see attachment) and approval granted by the ORP or the ORPs designee. Release of such data must be for official business needs of the Division or for Division-approved research activities. A minimum of five business days, from the date received, should be allotted for Division review and consideration. All data releases will exclude personally identifiable information, unless otherwise approved by the ORP and the Commissioner of Health. Access to any surveillance information for research purposes (other than routine surveillance) must be contingent upon a demonstrated need for the data, possible Institutional Review Board (IRB) approval, and the signing of confidentiality and data release agreements. As covered within the data release agreement (see attachment), such data are solely for the explicit use specified. Once the intended use of the data has been completed, all data must be destroyed or returned to the Division. No additional data extrapolations or usage is permitted, unless otherwise approved by the ORP.

The "Rule of Three"

In order to protect the confidentiality of persons reported with communicable diseases in Virginia, the Division of HIV/STD follows the Rule of Three as recommended by CDC. For the purposes of the Division of HIV/STD, the Rule of Three is interpreted as no dissemination of a data cell to the general public that involves 1) a particular demographic characteristic containing less than three (3), or 2) locality or region-specific data containing cells less than three (3), unless the data cell represents one entire year's worth of data. Likewise, if the contents of a suppressed cell in a table could be determined by simple mathematical calculations of the non-suppressed rows or columns, then the additional rows or columns also need to be suppressed. Any uncertainty regarding the release of such data should be clarified by supervisors. Any contractor that maintains data for the Division shall adhere to this policy.

Example of the Rule of Three:

RACE	#
White	100
Black	50
Native Amer.	1
Asian	1
Other	2

In order to prevent inadvertent disclosure of the individuals in the Native American or Asian categories, the information would be released as follows:

RACE	#
White	100
Black	50
Other	4

Security Breaches
Any suspected breach of security shall be reported to an employee's supervisor immediately, including both inadvertent and advertent breaches. The supervisor is responsible for immediately informing Division management of details regarding the incident and documenting the occurrence. Division management will immediately investigate the suspected breach to assess causes, implement remedies and through consultation with the Attorney General's office, determine whether the breach warrants reporting to appropriate law enforcement agencies. If a breach is determined to result in the release of confidential information about one or more individuals, the incident should be immediately reported to the Chief of the Reporting and Analysis Section, Surveillance Branch, DHAP-SE, NCHSTDP, CDC, by the ORP.

V. RAPID COMMUNICATIONS

Any confidential communication (written, verbal or electronic) shall be shared with other persons on a strict need to know basis. Confidential information shall be shared with an authorized individual as designated in Sections 32.1-36.1.A, 32.1-38 and 32.1.41 of the *Code of Virginia* only when an expressed need to receive such information is confirmed. Division staff shall exercise good judgment regarding the sharing of information.

Postal/Mailing Services
Incoming – Confidential information should be mailed to the Division of HIV/STD in a manner that does not allow information to be revealed without opening the envelope. The number of documents per envelope shall be kept to a minimum. All such information shall be folded towards the inside of the documentation prior to placement inside the envelope. Envelopes shall be taped shut as added security.

All mail incoming to the Division of HIV/STD is received within room 112. Incoming mail with confidential information should be sent to the Division of HIV/STD marked *Confidential, To Be Opened By Addressee Only* and shall be sent first class. Any envelopes or packages known or suspected to include confidential data-related information are forwarded by division staff to room 110 to be opened and date-stamped. This practice helps to ensure that confidential information remains unopened while in non-secure areas. All incoming mail is date stamped and distributed to appropriate Division staff daily; this is performed either in room 112 or room 110, depending on the nature of the mail. In the event confidential information is inadvertently opened in room 112, the documentation shall be immediately hand-delivered to the appropriate secure room.

Outgoing -- Confidential information should be mailed from the Division of HIV/STD in a manner that does not allow information to be revealed without opening the envelope. The number of documents per envelope shall be kept to a minimum. All such

information shall be folded towards the inside of the documentation prior to placement inside the envelope. Envelopes shall be taped shut as added security. All such confidential information mailed from the Division of HIV/STD shall be marked *Confidential, To Be Opened By Addressee Only* and shall be sent first class. The term Division of HIV/STD should not appear on the envelope if confidential information is enclosed.

Telephone

Incoming – Confidential information is shared over the phone with authorized Division staff for the purpose of morbidity reporting or for record searching treatment or morbidity history. Assistance with sharing confidential information through incoming calls shall only be completed if Division staff are 100% confident of the identity of the caller and he/she is an authorized recipient of such confidential information. Uncertainty regarding the identity of a caller should be verified via a call back procedure and/or discussion with appropriate personnel. If a call back verification is performed, Division staff shall not acknowledge this procedure to the caller. The caller's name, location and telephone number should be obtained and the caller informed that the Division will return their call as quickly as possible. When the call back procedure is performed, Division staff should receive immediate acknowledgement of the caller's location, etc. Any uncertainty regarding the caller's location or authorization to receive such information should be immediately forwarded to the Division employee's supervisor. Division staff shall not release any information if unsure of the legitimacy or authorization of the caller. In general, all such calls should be forwarded to Division staff who perform this type of task routinely.

Outgoing -- Confidential information is shared with persons outside the Division on a strict need to know basis and performed only in secure areas. In general, such calls are performed as a result of follow up to an inquiry or for updates to current morbidity reports and surveillance activities. Sharing confidential information through outgoing calls shall only be completed if Division staff are 100% confident in the identity of the recipient of the call and he/she is an authorized recipient of such confidential information. Division staff shall not release any information if unsure of the legitimacy or authorization of the recipient. Messages with identifying patient information shall not be left on voice mail systems. Unless otherwise instructed by supervision, these types of calls should only be completed by Division personnel that routinely perform this type of task.

Protocol for HIV/AIDS Record Searching Occupational Exposures

The following is the Division of HIV/STD protocol for conducting HIV/AIDS record searches for persons covered under the Deemed Consent Law HB 2416, Sections 32.1-45.1 of the *Code of Virginia*. Such occupational exposures may include needle stick exposures or blood or body fluid exposures. Personnel typically exposed to blood and body fluids are nurses, phlebotomists, police officers or emergency care workers. Health

Department employees may view *The Infection Control Guide* located on the internal web at http://vdhsrv15/epi/infindex.htm.

1. The record search inquiry should be directed to the appropriate regional HIV/AIDS Epidemiology Consultant (EC). If that person is unavailable, then the next available epidemiology consultant should take the request.
2. If medical information is requested, the call should be forwarded to a nurse.
3. The EC/nurse should document the following information:
   a) identity, position, and phone number of the person calling;
   b) reason for the record search;
   c) full name and date of birth of the source patient (additional demographic information as needed and if available);
   d) If the EC/nurse is unfamiliar with the person who is calling or uncertain if the caller has the authority to receive this confidential information, then the EC/nurse should separately confirm the caller's identity and authority to receive confidential HIV/AIDS information. If the EC/nurse has questions regarding this step, the EC/nurse should seek the guidance of his/her supervisor.
4. The EC/nurse should stress that if the source patient is not currently reported in the HARS database, the source patient could still be infected or seroconverting. In addition, the protocol of the local health department should be followed, and their Health Director should be notified of the situation. It should also be noted that CDC recommends that post exposure prophylaxis should be initiated within 12 hours of exposure.
5. If the occupational exposure involves a health care professional, the health department should be given the Post-Exposure Prophylaxis (PEP) hotline (1-888-448-4911) for further consultation, if needed.
6. The EC should complete the record search. Before releasing information, the EC/nurse needs to again stress that the Health Director should first be informed about this information.
   a) If the source patient is HIV positive, the health department should <u>not</u> disclose the infection status of the source patient to the person who was exposed. Post exposure prophylaxis should be started immediately if it has not yet been initiated.
   b) If the source patient is HIV negative, it should again be stressed that:
      1) the source patient could indeed be HIV infected and not currently reported within the HARS database, or,
      2) the source patient could be in the process of seroconversion.
   c) The Division of HIV/STD recommends that:
      1) the HIV source patient should be tested for HIV, and
      2) proper post exposure prophylaxis should be considered until the test results of the source patient can be received.
      3) tell the caller that the likelihood of transmitting hepatitis is ~100 times greater than transmitting HIV. Contact the Division of HIV/STD at 804-786-6267 for further guidance.

Electronic

Facsimile -- Confidential information shall be faxed with caution, using the utmost discretion. A telephone call should immediately precede any incoming facsimile that contains confidential information, such that the appropriate Division personnel is mindful of the document being faxed. The Division recipient of such a call should 1) verify the appropriate fax number being used by the caller, and 2) await the facsimile completion and immediately remove such documentation from the fax machine. If incoming faxes are not received within an expected time frame, the Division employee awaiting the facsimile should contact the sender. Completed facsimiles with confidential information shall not be left on fax machines unattended. All facsimile transactions involving confidential information should be received through a Division fax machine located in a secure area.

Outgoing facsimile transactions from the Division of HIV/STD shall follow the same guidelines as above. In addition, disease coding shall be used to reduce the likelihood of comprehension in the event the facsimile is received by unauthorized personnel. A fax cover sheet excluding identity of the Division of HIV/STD title should also be used. Fax machines used to send out confidential information should be programmed to indicate "Dept. of Health" on the top line of the faxed document, not "Division of HIV/STD." A log of all facsimiles, including sender's name, date sent, # of pages, fax # and location of receipt should be maintained.

Electronic Mail (E-mail)

Confidential information shall not be transmitted via e-mail, either internally (between Division staff) or externally (between Division staff and outside sources). E-mail is not secure and may be seen by more people than the intended recipient. Routine data requests minus personal identifiers may be sent using e-mail; however, the rule of three shall apply, where appropriate.

VI. FIELD ACTIVITIES

Field Transportation of Confidential Data

If confidential information is required for specific field-related activities, the information shall be carried in secured briefcases, include only necessary identifying information and exclude disease diagnoses (only disease codes shall be used). Any such information carried into the field shall never be left unattended. Confidential information shall be returned to the Division's secure area at the close of each business day. Prior approval must be obtained from immediate supervisors when out of town travel or some other reason precludes the same day return of confidential information. With rare exceptions, confidential information shall not be taken to private residences. Prior supervisory approval must be granted for these situations. Supervisors must document all events involving staff possession of confidential information in the field and/or taking such information to private residences.

Line-Lists – Line-lists are sometimes carried into the field to assist with active or sentinel surveillance activities. These line-lists shall be de-identified to ensure that the disease and risk status are coded for security and confidentiality purposes. Only patient information necessary for the specific field-related work for that date shall be transported into the field. Line lists shall be kept in the presence of the Division employee at all times when in the field. Line-lists shall not be left in vehicles. If the field-related work does not require an overnight stay, the line-list should be returned to the Division's secure area in the central office daily. Any diversion from this practice must have prior supervisory approval.

Laptops – Laptops are not currently used for routine field-related surveillance activities, although locking briefcases are available for any laptop used in the field with confidential information. The Division of HIV/STD is currently working with the Centers for Disease Control and Prevention on a pilot project to utilize laptops for accessing confidential data from remote sites. This project is referred to as the Secure Access Project (SAP) and when implemented, will allow for a selected review of HARS data from a remote location. Division staff who access this information via laptops need to remain cognizant of their surroundings at the remote location and ensure that others can not view the confidential information. A variety of additional security measures are being included in the project's design.

VII. PROCEDURAL REVIEW OF HIV/AIDS/STD SECURITY AND CONFIDENTIALITY

The ORP is the overall responsible party for all security and confidentiality issues. The Director of Statistics & Data Management is responsible for monitoring and ensuring the day-to-day security of Division of HIV/STD data and associated paperwork, with assistance from specified Division staff. Specific security precautions regarding the LAN and computer equipment are maintained by the HRDP User Liaison, who provides daily updates to the Director of Statistics & Data Management, as appropriate. Any problems, concerns or recommended changes for the enhancement of Division security are discussed with the ORP promptly.

The following list includes Division security activities describing specific items, dates and/or times the items are reviewed or completed, and the Division staff responsible for ensuring completion. A Division Security Report is generated by the Director of Statistics and Data Management on a yearly basis and provided to the ORP.

Division of HIV/STD Security Review Timeline

SECURITY ITEM	REVIEW TIMELINE	RESPONSIBILITY
Confidential file room	Opening/closing report monitored weekly	Director of Statistics & Data Management
Confidential file room	Descriptions of each alarm sounding, including tests, are hand-documented on weekly report	Director of Statistics & Data Management
Envelope of network passwords	Each change of a password	Director of Statistics & Data Management
Employment Checklist verification, including LAN, email, keys, etc. (primarily concerning ex-employees)	1) Immediately upon an employee's first and last work day 2) Annual review of checklist completeness	1) Immediate Supervisor 2) Director of Statistics & Data Management
Security & Confidentiality Guidelines	1) Resign guideline annually 2) Yearly review for updated signatures	1) Immediate Supervisor 2) Director of Statistics & Data Management
Data Recipient Agreements	Beginning and end of agreement. Periodic checks also performed.	Director of Statistics & Data Management
Equipment Logout Calendar	Daily review to ensure equipment return	HRDP User Liaison
Secure offices	Random checks to ensure doors and file cabinets are locked, PCs are off, confidential paperwork is appropriately filed, etc.	Director of Statistics & Data Management
Database logons	Randomly checked	Director of Statistics & Data Management
Network logons	Randomly checked	Director of Statistics & Data Management
Division Security Report	Provided to ORP yearly	Director of Statistics & Data Management

ATTACHMENTS

EMPLOYMENT CHECKLIST

Division of HIV/STD
Virginia Department of Health

Employee:_____ Position Number:_____

Emergency
Contact: _____ Phone Number:_____

Supervisor:_____ Position Number:_____

Item	Date Submitted	Date Completed	Date Returned/ Inactivated/Deleted
OHRM-20			
Employee Notification Letter			
OHRM-5			
Employment Eligibility Verification			*Do not*
Direct Deposit Form			*write in*
State/Federal Tax Forms			*shaded*
VDH Orientation Class			*area*
Security and Confidentiality Guidelines			
Security and Confidentiality Training			
VA Policy on Alcohol & Other Drugs			
Division Policies/Procedures Checklist			
Parking Permit			
Email Logon			
Network Logon ID			
State Identification Card			
Building Access Card			
Voicemail Code			
Office Key(s)			
Pager			
Cell Phone			
Laptop PC			
Portable Printer			
Other			

c: Supervisor
File

DIVISION POLICIES & PROCEDURES CHECKLIST
Division of HIV/STD
Virginia Department of Health

There are numerous issues that should be reviewed between the supervisor and any new employee. Your signature below serves as verification that the following issues were discussed with you and that any questions you had were answered.

ISSUE	REVIEWED
Confidentiality of Division Data (Security & Confidentiality Guidelines must be signed by each employee)	
Conflict of Interest (Security & Confidentiality Guidelines must be signed by each employee)	
Commonwealth of VA Policy on Alcohol and Other Drugs	
Employee Responsibility (Security & Confidentiality Guidelines must be signed by each employee)	
Break/Lunch Schedule	
Telephone Usage (for business purposes only)	
Daily Scheduling (begin and end times, promptness)	
Smoking Policy	
Fire Alarm Procedure	
Building Access (Access cards, after hours access)	
State Property Restrictions: Official Use Only (Copiers, Fax machines, PCs, Information Infrastructure)	
Vacation Approval	
Parking Permits/Payment Schedule (employee responsibility)	
Leave Form (annual leave, sick leave, family personal leave, proper procedures)	

Employee Name (print):_____

_____ _____
Employee Signature Date

_____ _____
Supervisor Signature Date

Additional Comments:_____

_____

_____

If additional comments are made, both the employee and supervisor should initial & date.

Employee:_____ Date:_____
Supervisor:_____ Date:_____

c: Employee
Supervisor
File

DIVISION OF HIV/STD
DATA REQUEST FORM

Requests for non-routine data, including any request for Division data sets, data matches or patient identifying information, must be submitted in writing to the Division of HIV/STD for data release consideration. Virginia Department of Health employees are exempt from this process; however, clear explanation should be provided regarding proposed data needs. Health department contractors or collaborators are not considered health department employees. Submission of this request does not guarantee approval and/or release of Division of HIV/STD data.

Submission Date:_____/_____/_____

Requestor:_____ Phone:_____-_____-_____

Title:_____ Fax: _____-_____-_____

Organization:_____ Email: _____

Purpose of Request:

_____
_____
_____
_____

Data Requested: [include timeframe(s), disease(s), demographics, etc]:

_____
_____
_____
_____

Data Use Methodology [if a research study/project, attach complete study design proposal]:

_____
_____
_____
_____
_____

Description of Data Protection Mechanisms [staff accessibility, electronic security, locks, etc]:

_____
_____
_____

At the conclusion of this project, the data will be: *(check one)*

! Returned to the Division of HIV/STD
! Destroyed
*(Method:*_____
_____)

_____
Signature of Requestor

cc: Data Recipient
Director of Statistics & Data Mgmt
File

DIVISION OF HIV/STD
DATA RECIPIENT AGREEMENT

The undersigned hereby agrees to the following terms and conditions relating to any data requested of the Virginia Department of Health Division of HIV/STD:

A. The information obtained through this data request will be used only for surveillance of treatment, care and/or disease trends, prevention strategies or for statistical purposes in medical and health research.

B. No data shall be released or published by the data recipient in any form potentially identifying a particular individual, physician, hospital or other reporting source. Data subsets without personal identifiers must comply with confidentiality guidelines based on data cell size, i.e. the "Rule of Three" as described by the Division of HIV/STD.

C. The data recipient shall sign the Division of HIV/STD Security & Confidentiality Guidelines. These guidelines shall be renewed every 12 months, as applicable.

D. Any identifying information in this data request shall not be used as a basis for legal, administrative, or other actions that may directly affect those particular individuals or establishments as a result of their specific identification in this project.

E. Information obtained through this request shall not be distributed to anyone else, including subcontractors and third-party analysts. The data shall not be used for any project other than the intended use specified in the data request.

F. Unless specified and approved through the original proposal, no "follow-back" investigations to obtain additional information from physicians, hospitals, or patients shall be undertaken.

G. All data received from the Division of HIV/STD shall be returned to the Division or disposed of by an approved method at the end of the project. The data recipient shall state the method of return or disposal prior to receipt of the data.

H. Any suspected or confirmed breach of data confidentiality or security shall be immediately reported to the Director of the Division of HIV/STD.

I. Draft versions of all work products shall be sent to the Division of HIV/STD for review prior to any distribution. Sufficient time should be allotted to allow for review and comments prior to distribution.

J. A copy of all final work products resulting from use of the data shall be sent to the Division of HIV/STD prior to or at the time of distribution.

As a recipient of data from the Virginia Department of Health Division of HIV/STD, I agree to abide by the above stipulations.

Signature: _____ Date: _____

Organization: _____

cc: Data Recipient
Director of Statistics & Data Mgmt
File

Information contained in this section includes:

Part I. STD Clinic Structure and Management

A. Accessibility
B. Range of Services
C. Clinic Environment
D. Registration Process
E. Clinic Flow
F. Medical Records
G. Clinic Management Structure
H. Clinic Manuals
I. Clinician Roles and Performance Standards
J. Universal Precautions
K. Emergency Procedures
L. Stat laboratory Management Structure
M. Laboratorian Roles and Performance Standards
N. Laboratory Practice and Techniques
O. Disease Intervention Specialist Component
P. Quality Assurance Procedures
Q. Reporting Requirements

Part II. Clinic Protocols for Patient Management

A. Patient Evaluation
B. Patient Management of STD
C. Medical Consultation and Referral
D. Follow-Up to Therapy
E. Counseling/Education
F. Management of Sex Partners

- Equipment and Supplies
- Registration
- Medical Records
- Performance Evaluations
- Medical Care
- Laboratory Services
- Disease Reporting

Introduction

The guidelines on clinical management and medical protocols were established after consultation between outside experts and staff at CDC and were field-tested in a series of clinical reviews. The developing concept of clinical practice guidelines, which is designed to categorize various medical procedures and interventions into standards, guidelines, or options, is set within the context of a clinician's available choices for the management of a patient. While the conventional specifications of these categories do not precisely apply to the purposes of this document, the general definitions are certainly appropriate. They state that:

> A *standard* is intended to be rigidly applied and applied in virtually all cases. Exceptions will be rare and difficult to justify. The agreement level is set at a minimum of 95%.
>
> A *guideline* is intended to be more flexible; it should be followed in most cases. However, a guideline can and should be tailored to fit individual needs. The agreement level is set between 60% and 95%.
>
> An *option* is neutral with respect to recommending use, and it leaves the practitioner free to choose any available course.

Applying this general concept of clinical practice guidelines to STD prevention and control requires the adoption of specific definitions for standards, guidelines, and options that are appropriate to the circumstances. Those circumstances differ within the parts of this document. Specifically, Part I is concerned with the organization, operation, and management of an STD clinic. Part II presents the clinic protocols for patient management.

Definitions for Part I are:

> A *standard* is a consensus among experts in STD clinical services that the practice or technique is essential to an effective and efficient clinic operation.
>
> A *guideline* is a consensus among STD clinic experts that the practice or technique is important enough to the clinic's mission that it should be accepted unless documentation from the particular setting shows otherwise.
>
> An *option* is a consensus among STD clinic experts that the practice or technique is helpful but not critical to effective and efficient clinic operations.

The definitions for Part II are tailored to the medical management of patients with various sexually transmitted conditions and are more consistent with conventional clinic practice

guidelines. Options are not included because, in this field, all practices or techniques seem to fall into either the standard or guideline category. The definitions are:

> A *standard* is a practice or technique that nearly all (greater than 95%) STD clinical practitioners agree is essential and appropriate for the medical management of a patient.
>
> A *guideline* is a practice or technique preferred by an appreciable number or a majority (60% - 95%) of STD clinical practitioners who agree on its overall desirability.

One difficulty in writing such a document is the difference in administration and resources among various clinics offering STD diagnostic services. The model protocols provide a framework for clinical practice and may be reproduced, expanded, and amended by local policies and procedures for use in local clinics. However, these clinical practice guidelines are a composite of decades of experience and study; any decision to deviate from the clinical practice guidelines should be based on empirical evidence that a specific practice or technique is not appropriate for a particular clinic. These protocols may be incorporated by other non-traditional STD clinics where the target population seeks health care (e.g., family planning, adolescent health, prenatal care, college health, drug treatment, primary care). Persons who are seeking health care services for other reasons, but who are at risk for STDs, should be evaluated according to these guidelines.

Part I.
Clinic Structure and Management

The STD clinic is a central element in the prevention of sexually transmitted diseases within the community. Integrating HIV testing, counseling, and treatment into routine STD care has increased the demand for services. All elements of clinic operation, from administration to the range and quality of services, affect the ability of the STD clinic to play this critical role in disease intervention.

A. Accessibility

STD clinics should provide convenient and cost-effective clinical services. These services should be confidential and organized to minimize physical, social, and/or economic barriers encountered by patients seeking care. The optimal operating hours for a clinic may be determined by analyzing the demographic characteristics and culture diversity of the population to be served. Assessing the proportion in school or employed and the location of the population with the highest prevalence of STDs within the community is also important. Each clinic should examine alternative hours of operation to determine the hours that are most convenient for the greatest number of patients.

Standards

- Clinic hours should be sufficient to accommodate the average daily patient load.
- The clinic should remain open continuously during lunchtime in order to operate efficiently and avoid down time as a result of closing and reopening.
- Clinics should be open at least three days a week to allow the scheduling of return visits and sufficient opportunity for symptomatic persons to attend.
- Clinic services should be free. When fees are necessary, they should be minimal or on a sliding scale. Services or medications must never be withheld because patients cannot pay a fee.
- Fees should not be assessed for examining persons referred by a disease intervention specialist (DIS) (eg., partner notification, referral for testing).
- The clinic should be listed in the government and the classified sections of the telephone directory and in a list of frequently called numbers under a heading that is readily understandable to clients.

Guidelines

- Evening or Saturday services should be available each week to allow patients who work during the day to be seen.
- Fees should not be assessed for examining persons who are referred to the clinic for medical care by other health professionals.
- Clinics, particularly new ones, should be located so that they are readily accessible through public and private transportation from residential areas.
- The clinic should be advertised in locations and through media utilized by high-risk populations.
- The clinic should be listed in community medical resource directories.
- A telephone answering device should provide information about clinic hours to after hours callers.

B. Range of Services

STD clinics should provide basic STD prevention services emphasizing the service needs of the diverse population within the community. This means testing for, diagnosing, and treating locally prevalent STDs to the maximum extent possible; it especially means identifying and managing STDs for which disease intervention services are being targeted to prevent further transmission. The size of the area, degree of urbanization, and local health department resources often have a role in determining the range of services. Because disease outbreaks can seriously affect a locality, public health considerations should weigh heavily in setting priorities that affect the range of routine STD clinical services.

Standards

- Clinics should have the capability to evaluate and treat persons for all locally prevalent STDs.
- At a minimum, clinics should provide diagnostic treatment services for priority diseases--those targeted for disease intervention (e.g., syphilis, gonorrhea, chlamydia, and chancroid).
- Clinics should distribute medications for all diseases diagnosed in the clinic. At a minimum, medications should be available for priority diseases, with prescriptions substituted for diagnosed diseases of lesser public health importance if resources are lacking.
- The clinic should provide the basic range of HIV-related services specified in state and federal statutes and, for patient convenience, should offer as many as possible on site (e.g., treatment and testing).
- Confidential counseling and testing for HIV should be offered at the time of the STD visit so that patients do not have to visit separate

clinics or make return visits.

- Anonymous HIV counseling and testing should be available on site for patients requesting the service or at community sites convenient to patients.
- Arrangements and procedures should be established for the referral of patients for HIV early intervention services (e.g., continuing medical evaluation, tuberculosis and immune system testing, treatment, and support group counseling).
- When not offered on site, the mechanism for referrals for relevant health services should be established (e.g., family planning, prenatal, adult immunizations).

C. Clinic Environment

The quality of the physical facility as well as the professional attitudes of staff influence a patient's impression of clinic services. Distinct public health benefits can come from maintaining an aesthetic and professional environment. The environment should reinforce confidentiality and support health education directed toward positive behavior change.

Clinic Identity

Standards

- The building that houses an STD clinic should have signs making it easy to locate, and it should be recognizable as a health care facility.
- Signs at the building entrance should be easy to read and should list the STD clinic among the services.
- Other signs in the building directing persons to the STD clinic should be clear and prominent.

Guidelines

- The door to the STD clinic should be unobtrusive to avoid calling attention to or stigmatizing persons who enter to access services.

Waiting Areas

Standards

- Waiting areas should be clean, maintained at a comfortable temperature, and large enough to accommodate all patients.
- Waiting areas should be constructed so that registration information can be obtained in a confidential manner.

- All patient education materials should be linguistically and culturally appropriate for the client population and at the appropriate reading level.
- The concept of confidentiality should be promoted by using numbers rather than names when calling patients from the waiting areas; numbers may be less necessary in facilities where STD patients wait in a common area with persons seeking services from other clinics.

Guidelines

- Waiting areas should have posters, pamphlets, or audiovisuals that inform patients of the clinic hours; what they should expect in the clinic; and list any costs that patients may incur (e.g., medications or fees).
- Waiting areas should contain patient education handouts that stress disease intervention behaviors (e.g., ensure the examination of all sex partners, reduce risk by using latex condoms and by avoiding sex until partners have been examined, respond to future suspicion of disease whether or not symptoms exist and, when applicable, take medication and return for follow-up tests).
- The literature in waiting areas should also contain specific messages about the prevention of HIV infection (e.g., avoid sharing needles, decontaminate drug injection equipment, inform women of reproductive options).

Examination Rooms

Standards

- Examination rooms should be clean and private; they should be separated from the waiting area so it is not possible to overhear or to see patients who are being examined.
- Examination rooms should have adequate equipment and supplies for physical examinations and specimen collection for both male and female patients.
- The clinic should have an effective system for monitoring and replenishing supplies.
- Chairs which ensure patient safety during phlebotomy should be available in each room where blood is drawn.
- The number of examination rooms should be adequate to accommodate the number of clinicians (at least one per room per clinician) and to serve the patients promptly during the normal working day.

Guidelines

- Space permitting, clinicians should be assigned two examination rooms; introduction, history, examination, and specimen collection should take place in one room while the patient in the second room is awaiting the clinician's return with laboratory results and diagnosis.

Patient Consideration

Standards

- In all interactions with patients and with other staff, clinic personnel should be courteous and respectful of individual dignity.
- Sensitivity to confidentiality should govern any discussion among clinic staff about a patient's history, medical findings, or test results; discussions should not take place in the presence or within the hearing of another patient, relative, or guardian without the specific consent of the patient.
- All clinic staff should possess cross-cultural awareness and exhibit a cultural sensitivity to establish a positive clinic-patient relationship.
- Children should not be used as interpreters.
- When a segment of the patient population has a primary language other than English, an adequate portion of the clinic staff should have bilingual fluency that facilitates services to those patients.

D. Registration Process

Registration should not be a bottleneck in STD clinics. A well-trained clerical staff and a well-organized clerical system expedite patient flow at this critical point. A patient should not have to repeat his or her medical history to other staff members before seeing a clinician. Registration personnel see patients first; therefore, they set the tone for the visit and must be sensitive to their role in influencing patient attitudes.

Confidentiality

Standards

- Registration clerks should focus on confidentiality by lowering their voices and limiting the exchange of information in waiting areas.
- A person's race or ethnic identity should not be assumed by the clerk, but clarified by the person registering.
- Acoustical barriers separating clerks from waiting areas should be considered when distance does not prevent persons from overhearing

those who are registering.

- When privacy is lacking, the clinic should utilize self-registration in which no sensitive information is exchanged verbally.
- Information collected at the registration desk should be relevant: locating and demographic data, type of visit (referral, appointment, or walk-in).
- Clerks should avoid discussing the medical reason for the visit including any symptoms or medical history. Clerks who perform telephone triage or who prepare laboratory request forms in advance should ask the minimum information to complete the task and should not make medical decisions or chart the course of a person's visit.

Guidelines

- Verification of patient identities at registration should be conducted if evidence* suggests it is needed to ensure appropriate care and that public health concerns are addressed.

  * **A clinic which is failing to locate a substantial proportion of patients needing STD follow-up testing, treatment, or disease intervention services because of false identities or addresses should consider a policy to request positive identification at registration. Someone should speak with patients who cannot identify themselves to explain the importance of giving accurate information. However, clinical, counseling, or other services must never be denied because a patient declines to provide identification. In addition, clinics offering anonymous HIV antibody counseling and testing should advertise a waiver of positive identification for persons seeking that service only.**

Procedure

Standards

- Clinics should have an appropriate number of clerical staff to register persons promptly and should register continuously by staggering lunch hours and breaks.
- When local protocols require written consent to be examined, tested, and treated for STDs, this should be obtained from persons when they register.
- Registration clerks should assign numbers to persons by order of arrival and should provide information, through a handout or verbally, about what to expect in the clinic (e.g., clinic hours, fees, confidentiality, a brief description of the physical examination, and that patients may sometimes be called out of turn if their evaluation is expected to be very quick).

- Clinics should have "fast-track" registration procedures, such as assigning letters instead of numbers for persons who have priority referrals.
- The "expected-in"* file should be checked routinely as part of the registration process to identify persons who have been referred by a DIS for examination, who need repeat serologic tests for syphilis (STS) or who require HIV test counseling.

  * **"Expected-in" is a record file of pending follow-up priority examinations for disease intervention for the following: persons with reactive test results and untreated from the clinic or other facilities; sex partners or cluster suspects of diagnosed patients; and persons who need special repeat testing. By attaching the "expected-in" notice to a chart, clinicians have medical information sufficient to provide immediate treatment.**

- Staff members who report test results over the telephone (HIV test results should not be given over the telephone) should use a security procedure that requires callers to use identifiers not likely to be known by an acquaintance (e.g., clinic number, date of visit, birth date).

E. Clinic Flow

Clinic flow should facilitate the effective use of personnel and physical facilities while preserving concern for the patients. Clinics should routinely evaluate space and financial resources critical to providing adequate services. Integrating HIV-related services into routine STD services may lengthen the clinic visit, but it need not create additional stops. The sequence should be logical so that confusion or unnecessary delays for the patients are avoided. The philosophy of clinic flow should emphasize that staff move when necessary and that patients be required to make as few moves as possible. A procedure should be established to accord expedited care to any patient referred by a DIS, returning for HIV test counseling, or attending for follow-up examinations.

Combined Appointment and Walk-In Systems

Standards

- Any clinic whose average patient volume exceeds two to three patients per clinician per hour should evaluate the need for additional clinicians and cross-training to provide coverage at peak times.
- Where triage is performed, walk-in patients with genital ulcers, discharges, and women with abdominal pain should be examined that day.
- Walk-in patients who are not examined within the day should be provided a list of STD medical resources and eligibility requirements

(e.g., emergency rooms, urgent care clinics, family planning clinics, private physicians) and encouraged to call for a next-session appointment if services are still needed.

- The initial patient visit should take no more than 1.5 hours from registration to treatment. (This does not include sessions with DIS for HIV test counseling and partner notification purposes which will vary in length depending on the STD diagnosis, HIV counseling circumstances, and individual patient needs.)

Guidelines

- Clinics in which walk-in patients wait over 30 minutes to be examined should adopt a combined appointment and walk-in system to improve patient flow.

Recommended Patient Stops

Standards

- Clinic flow should be designed so that the next available clinician sees the next patient registered, regardless of the patient's gender* or complaint.

  * **An exception may be made where local medical practice standards or legislation places requirements on clinicians in performing examinations on the basis of gender. Patients who request a clinician of a specific gender should be accommodated whenever possible.**

Guidelines

- Patient stops should be kept to a minimum (ideally, not more than three--registration, clinical care, and an STD/HIV interviewing/counseling session, if needed).
- The clinical care stop (with one clinician) should include history taking, examination, the collection of blood* and other specimens, diagnosis, treatment, and counseling about therapy, follow-up, and the prevention of future infection.

  * **Individual clinicians can safely perform phlebotomy in the examination room if they observe universal precautions. Special stops (such as phlebotomy or treatment) often become a bottleneck. They tend to compromise efficient clinic operation with delays for patients because of the need for specialized staff, reducing the number of examination rooms, and creating separate waiting areas.**

Options

- An analysis of patient flow should be conducted to provide a systematic understanding of where bottlenecks in clinic flow occur.

F. Medical Records

The format, composition, and maintenance of medical records are crucial. Review of the medical records can determine whether clinicians are consistently following established protocols, thus ensuring quality care for patients. Clinics which extend testing, treatment, and other early intervention services for HIV infection will need additional information.

Design/Contents

Standards

- Medical records should contain minimum demographic information to identify and locate the patient promptly.
- Records should have a check-off design and should comprise symptoms, medical history, physical examination findings, diagnoses, treatment, and laboratory tests appropriate for common STDs.
- For auditing purposes, clinicians should be required to mark each item on the clinical evaluation and the laboratory test sections, reactive or nonreactive, done or not done, normal or abnormal.
- Additional space should be allotted for a brief narrative description of items not printed in the medical evaluation categories.
- Medical records should contain sufficient clinical evaluation information so that any person approved to look at a record can readily interpret the examining clinician's assessment and clinical findings.
- Additional information on medical records should include HIV risk assessment, drug use (parenteral and other), relevant sexual history, counseling, and plans for follow-up or referral.

Guidelines

- Information gleaned during the examination and not used in making a medical assessment should not be written on the record.
- In areas of high HIV prevalence, additional information may be included such as history of tuberculosis (including exposure and infection).

Filing System

Standards

- Medical records should be removed from desk tops and filed in locked desk or file drawers at the end of the day.
- Medical records should be stored in locked files or locked rooms that are easily accessible to clinic personnel but inaccessible to unauthorized persons.
- Computerized medical records need rigorous access protection procedures to prevent unauthorized entry into the file, as well as back-up filing to prevent the loss of information.

Guidelines

- Medical records, along with laboratory reports, referral forms, and other pertinent information should be kept in coded files.
- Clinics should follow a formal procedure for purging medical records according to program guidelines and record retention statutes.

G. Clinical Management Structure

Clinics should have one person (usually the clinic manager) who has the authority to develop and implement clinic goals, policies, and procedures, as well as to manage personnel, orchestrate all clinic functions, and ensure quality of care. Delegation of clinic manager functions depends on clinic resources, staffing, and space. Working as part of the clinic management team, the medical director supports and complements the efforts of the clinic manager by carrying out a number of special medical duties. The interrelationship among management staff (clinic manager, medical director, laboratory director, DIS supervisor, and other supervisory staff) is critical to accomplishing STD prevention program objectives.

Clinic Manager

Standards

- Job qualifications for clinic manager:

    1. Adequate medical training to make valid comparisons between observed clinician performance and clinic protocols. The nonmedical clinic manager should have adequate medical knowledge to make comparisons between the clinic protocols and the findings of a medical professional (e.g., clinic supervisor)

delegated to evaluate clinician performance.
2. Specialized STD training (see Clinician Performance Standards).
3. Management training to operate the clinic effectively.
4. Public health experience or an orientation toward STD intervention concepts and activities to understand the needs of DIS supervisors and staff.
5. Understanding of standard laboratory procedures and methods to coordinate clinical and laboratory functions effectively.

- The clinic manager should have the necessary training and authority to carry out various personnel management responsibilities relating to:

1. accurate job descriptions and reasonable performance standards for clinicians;
2. staff orientation, familiarity with work plans, and knowledge of performance expectations;
3. adequate staffing to care for the patient population (even when vacations are scheduled); and,
4. staff training and updates in STD patient management and universal precautions.

- The clinic manager should also ensure that:

1. clinic policies and procedures are developed, implemented, and updated;
2. the clinic manual is current and accessible to all employees;
3. information is communicated to all staff through regular (at least twice monthly) staff meetings and that staff are encouraged to make suggestions about policies;
4. universal blood and body fluid precautions are observed by all personnel;
5 patient flow is optimal including developing policies for triage
6. quality assurance procedures for the clinical aspects are implemented and maintained;
7. the clinic facility, including equipment and supplies, is adequate for the patient population; and,
8. that appropriate medical oversight is available as needed.

Medical Director

Standards

- The responsibilities of the medical director should include:

    1. signing standing orders for nonphysician clinicians and acting as the final authority on medical care in the clinic;
    2. being in the clinic, being available, or arranging for physician coverage in the director's absence, for consultation with nonphysician clinicians during all clinic hours;
    3. assisting with the training of clinicians who need help to improve or upgrade their clinical practices;
    4. assisting the clinic manager in clinician performance evaluations;
    5. routine auditing (personally or by delegation) of all medical records to ensure that diagnoses are consistent with clinic protocols; and,
    6. ensuring that the quality assurance committee's recommendations concerning medical care are implemented.

H. Clinic Manuals

Personnel Policies

Standards

- An STD clinic manual should contain the goals and the objectives of the clinic, including fully integrated STD/HIV services.
- Job descriptions and performance standards should be provided for all staff (clinicians, DIS, clerks, laboratory technicians, and medical director). These descriptions and standards should include:

    1. qualifications and training requirements for each job;
    2. the role each job plays in the operation of the clinic;
    3. a description of the tasks required for each job;
    4. the mechanism for performance evaluation; and,
    5. attitudes expected to be conveyed to clinic patients.

- Policies regarding employee health (e.g., injury surveillance, tuberculosis screening, and hepatitis vaccination) should be consistent with state employee health regulations and be clearly written and enforced.
- Procedures for formal quality assurance should be provided.

- Local policies and procedures included in the manual (frequency of staff meetings, fire drill instructions, sick leave, and vacation) should be current.

Medical Protocols

Standards

- Clinic protocols or standard medical instructions for specific patient management should include:

  1. patient evaluation;
  2. management of STDs;
  3. medical consultation and referral;
  4. follow-up after therapy;
  5. counseling/education; and,
  6. management of sex partners.

- Protocols should include current recommended treatments for STDs.
- Emergency medical protocols should be current.
- Protocols for the safe handling of blood and body fluids (universal precautions) should be current and practical for most clinic situations.
- Current and signed standing orders* for nonphysician clinicians should be included if required by state laws and regulations (medical practice acts).

  * **Standing orders are the signed instructions of a physician which outline the medical assessment, appropriate testing, and treatment that a clinician may perform or deliver on behalf of the physician. In some states, nonphysicians are authorized to perform assessments and prescribe medications independently. Standing orders also serve to standardize the clinical care practiced by all clinicians.**

I. Clinician Roles and Performance Standards

Properly trained and adequately supervised nonphysician clinicians can manage most uncomplicated STDs and can recognize the signs and symptoms of HIV infection. Nursing and physician assistant roles should not be limited to history taking, assisting physicians, and dispensing medication. Having a single clinician manage each patient lessens the patient's sense of fragmentation and impersonal interaction; it also improves patient flow and patient satisfaction. Patients' perceptions and experiences of the examination influence their willingness to comply with staff instructions at any step in the process.

Clinician Roles

Standards

- Nurses, nurse practitioners, and physician assistants should work, following clinic protocols, as clinicians* responsible for the entire clinical care process, including history taking, physical examination, laboratory specimen collection, diagnosis, treatment, plan for follow-up, and counseling/education.**

  * **The extent to which various categories of nonphysicians can function as clinicians is defined in medical practice statutes and legal precedent in each state/locality.**

  ** **As with any other clinical practice or STD counseling responsibilities, clinicians who perform HIV pretest counseling or partner notification should receive specific skill training and should be evaluated regularly in these skills.**

Performance Standards

Standards

- Minimum background and training includes:

  1. licensure (i.e., registered nurse, nurse practitioner, physician assistant, or physician) or credentials required by the state or locality to perform the functions of an STD clinician;
  2. preceptorship for new clinicians, who are developing skills,* before caring for patients under protocols.

     * **Under the guidance of preceptors, clinicians learn to perform bimanual pelvic examinations. Through monitored practice, they maintain and enhance their skills by evaluating large numbers of patients to be able to differentiate between normal and abnormal findings.**

- Specific training for clinicians inexperienced in STD examinations includes:

  1. completion of training entitled Comprehensive or Intensive STD Clinician Course at an STD Prevention/Training Center or a similar course;
  2. completion of an AIDS Update Course, or equivalent, that includes clinical and epidemiologic information about HIV infection;

3. a course in HIV Antibody Pretest and Posttest Counseling, if this service is a clinical care responsibility; and
4. certification or special training in Mantoux skin testing for tuberculosis (when testing is provided in the clinic).

- Clinicians should present an image of sensitivity and competence to the patient.
- The medical history and the risk assessment should be obtained by asking open-ended questions (e.g., how long, when, how many, what).
- Clinicians should respect the confidentiality of all patient information.
- Clinicians should examine all appropriate anatomy with professional thoroughness.
- All laboratory specimens should be collected and labelled correctly.
- The examination, diagnosis, and treatment should be accurate and should be noted in the medical record.
- Counseling messages should be specific, clear, and brief, allowing time for patients' questions.
- Clinicians should consult with the medical director on decisions that require a higher level of professional expertise.
- Clinicians should strictly adhere to universal blood and body fluid precautions.
- Clinicians should inform the patient who will receive DIS services that another member of the health department staff will assist them. Making the introduction, or at least providing the name of the DIS, makes the transition more comfortable.

J. Universal Precautions

Universal precautions should be observed by all clinical personnel for all patients as part of routine infection control.* Clinicians, laboratory technicians, and phlebotomists routinely come into contact with blood and body fluids during the course of examination and testing. Blood is the single most important source of infection with HIV and hepatitis B virus (HBV) in the workplace. The potential for HBV transmission in the clinic is greater than for HIV. Health care workers should be particularly alert to the need for preventing tuberculosis transmission in settings in which persons with HIV infection receive care, especially where aerosolized pentamidine treatments are being performed.

* **Those clinics performing invasive procedures defined as "surgical entry into tissues, cavities, or organs or repair of major traumatic injuries" should comply with the document, Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures.**

Standards

- Universal precautions should be applied to blood, vaginal secretions, semen, to other body fluids if they contain visible blood, and when there is potential for exposure to abnormal discharges from any body-opening or lesion.
- Protective barriers should be appropriate for the type of exposure anticipated and may include latex or vinyl gloves, gowns, masks, and protective eye wear.
- Needles and syringes should not be recapped or removed from disposable syringes.
- Disposable syringes and other sharp items should be placed in puncture-resistant containers for disposal
- Gloves should be worn during phlebotomy* to reduce the incidence of blood contamination of hands, recognizing that they cannot prevent needle-stick injuries.

  * **Regardless of clinic policy, gloves should be available at all times and should always be worn by persons receiving training in phlebotomy or who have cuts and abrasions.**

- Clinicians and phlebotomists should change gloves between patients.
- Gloves should not be worn outside the examination room or the laboratory.
- Hands or other skin should be immediately and thoroughly washed if contaminated with blood or body fluids. Hands should always be washed before and after the examination and before leaving the examination room.
- Infectious waste should be incinerated or autoclaved before disposal in a sanitary landfill.
- Aerosolized pentamidine treatments should be administered in an individual room or booth with negative pressure relative to adjacent rooms and hallways, and ideally with room air exhaust directed to the outside.
- A surveillance system should be established for injuries such as needle-sticks, percutaneous injuries, and mucous membrane contamination; protocols should specify collection of confidential information about the worker, cause of injury, medical care and treatment, and counseling and follow-up.

Guidelines

- All workers to whom universal precautions apply should receive the hepatitis B vaccine.

- Each clinic in which persons with HIV infection receive care should have a policy for Mantoux tuberculin skin testing of all health care facility workers (not just those interacting with patients). A baseline skin test administered within two weeks of employment and a follow-up based on the prevalence of tuberculosis in the patient population and community is suggested.

K. Emergency Procedures

STD clinics should be prepared for medical emergencies, particularly life-threatening drug reactions. Preparation should entail having established procedures, adequate and properly maintained equipment, and appropriately trained staff.

Standards

- One copy of the emergency protocol should be kept in the clinic manual and one copy with the emergency supplies.
- Emergency equipment, supplies, and medications should be updated frequently according to an established schedule to ensure that they are not depleted or expired. Emergency supplies should be sealed when not in use.
- All clinical staff should be trained in cardiopulmonary resuscitation and, at a minimum, should know what to do in emergencies.
- Staff should be prepared in specific safety procedures for managing potentially violent or abusive situations in the clinic.

Guidelines

- Emergency drills should be held at least twice yearly to ensure that all staff recognize emergencies, know their roles and protocols, know the location and contents of emergency supplies, and can use all equipment properly.

L. Stat Laboratory Management Structure

An on-site laboratory prepared to perform immediate (stat) high-quality testing to assist with the diagnosis of various STDs is an indispensable component of any contemporary STD clinic. The stat laboratory may be independently managed by a laboratory director on site or be a satellite laboratory of a local or a state health department laboratory. Links with reference laboratories for nonroutine or special testing provides comprehensive coverage for clinical services. Routine stat testing should be completed before the patient leaves the

clinic. All laboratories must comply with state and federal regulations governing diagnostic testing.

Laboratory Direction

Standards

- The laboratory director should be trained in appropriate laboratory techniques and safety procedures associated with handling infectious agents.
- The director should have experience in public health and an understanding of the needs of clinicians and DIS staff.
- Staff should be familiar with work plans and receive ongoing performance evaluations.
- Only personnel who have been advised of potential hazards and who meet specific entry requirements should be allowed to enter the laboratory.
- The director should ensure adequate staffing to manage the volume of rapid testing during peak testing hours and during employee vacations.
- All persons working with potentially infectious agents and materials should be trained in universal precautions and be proficient in the practices and techniques required for safe handling.
- Accurate and updated test procedures and biosafety manuals should be available to all laboratory employees.
- Policies should be established to ensure the confidential storage of laboratory requisitions* or log books containing patients' test results.

  * **As is true of STD medical charts, confidentiality statutes in each jurisdiction define the records that are protected from subpoena and may specify the time frame for retention and the method for destruction.**

Guidelines

- Optimal qualifications of the laboratory director include a doctoral degree in medicine or laboratory science.
- The director should ensure that the quality assurance committee's recommendations for laboratory testing are implemented.

Laboratory Services

Standards

- Each clinic should have an on-site stat laboratory.

- The stat laboratory, at a minimum, should perform the following tests:

  1. Gram stain to detect intracellular gram-negative diplococci and presence of white blood cells (WBC; also called polymorphonuclear leukocytes, PMN) to detect cervicitis or urethritis (often associated with Chlamydia trachomatis and Neisseria gonorrhoeae);
  2. Culture for N. gonorrhoeae (presumptive determination ideally, incubation at a minimum);
  3. tests for C. trachomatis;
  4. nontreponemal antibody card tests for syphilis, e.g., Rapid Plasma Reagin (RPR) or other approved qualitative and quantitative rapid test (stat testing for priority diseases: sex partners and clusters to syphilis and for patients with genital ulcers);
  5. darkfield examination for Treponema pallidum;
  6. saline wet mount for Trichomonas vaginalis and detection of "clue cells" of bacterial vaginosis;
  7. KOH wet mount for the identification of yeast; and,
  8. urine pregnancy tests

- The stat laboratory should contain an appropriate number of brightfield and darkfield microscopes* and adequate equipment, supplies, and reagents to process patient specimens rapidly.

  * **In an efficient clinic, each laboratorian should have access to a brightfield microscope. At least one darkfield microscope, or the ability to convert a brightfield microscope for use as a darkfield microscope by interchanging condensers and altering objectives, is necessary. There may be a need for additional darkfield microscopes in areas with a greater prevalence of genital ulcer disease.**

- The stat laboratory should have the backup of a reference laboratory for routine test procedures which include:

  1. presumptive and confirmatory identification and antimicrobial sensitivity tests for N. gonorrhoeae;
  2. chlamydia diagnostic tests (culture, enzyme immunoassay, direct fluorescent antibody, or nucleic acid hybridization [DNA probe] techniques);
  3. qualitative and quantitative nontreponemal antibody card tests for syphilis (routine tests);
  4. fluorescent treponemal antibody absorption and microhemagglutination or other treponemal tests for syphilis; and,

5. HIV antibody tests.

Options

- Additional stat testing may include:

  1. Tzanck stain for herpes
  2. spun urine for Gram stain and white cell count

- Reference laboratory services which further facilitate the diagnosis of STDs include cultures for C. trachomatis, H. ducreyi, T. vaginalis, herpes simplex virus, cytomegalovirus, and enteric infections (campylobacter, salmonella, and shigella); ova and parasite examinations; serologic testing for hepatitis B virus and herpes simplex virus, and lymphocyte (CD_4+) cell counts for HIV infection.*

  * **The development and expansion of early intervention services for HIV is likely to require the availability of other laboratory tests through referral. Clinics should remain alert to recommendations in this regard.**

M. Laboratorian Roles and Performance Standards

Quality stat laboratory testing by trained personnel contribute to rapid diagnosis and efficient clinic flow. Laboratory testing is inherently amenable to objective, ongoing methods of quality assurance. The employment of personnel without specific laboratory training to routinely perform laboratory tests may increase the risk of error and without adequate staffing may dilute the effectiveness of their regular work (e.g., DIS, nurses, and physicians). Funding sources, civil service rules, and recommendations of professional organizations may be used in establishing the academic qualifications for stat laboratory technicians.

Standards

- Job qualifications for laboratorians include:

  1. at a minimum, high school graduation and training received at a medical/technical school. Certification as a laboratory technician or technologist, professional registration as a microbiologist, or a degree in biological science; and,
  2. courses in basic stat laboratory methods for STD testing: brightfield and darkfield microscopy, gonorrhea culturing, rapid chlamydia tests, and syphilis serology at one of the STD Prevention/Training Centers or similar training.

- All laboratory workers should routinely undergo proficiency testing.
- A laboratorian should possess a professional attitude and a sensitivity about confidentiality; this includes not discussing laboratory results within patients' hearing.
- A laboratory worker should adhere strictly to universal precautions, safety procedures, and quality control procedures.

N. Laboratory Practice and Techniques

The basic stat laboratory should adhere to the recommended practices and techniques for a Biosafety Level 2 facility. The laboratory should be close to the examination rooms for easy access by clinicians who are transporting specimens; however, it should be separated from public areas and general offices where non-laboratory staff require frequent access. Each facility should develop or adopt a biosafety manual. All current microbiologic procedures used in the laboratory should be described in at least one manual that is available to all employees. All staff responsible for performing laboratory testing should adhere to the recommended microbiologic practices and follow approved procedures.

Microbiological Practices

Standards

- All procedures should be consistent with recognized standards and specialized microbiologic practices.
- Biological safety cabinets, previously termed "hood," (Class I or II) or other physical containment devices such as the safety centrifuge with securely locking top should be used during procedures in which infectious aerosols may be created.
- Any activity with the potential for creating aerosols (e.g., centrifugation of blood) should be performed in low-traffic areas in the laboratory.
- All testing should be performed under quality assurance guidelines specific for each test (e.g., control specimens, temperature, time).
- Safety equipment should include items for personal protection such as gloves, coats, face shields, and safety glasses.
- Especially when the stat laboratory is at a distance from the clinic, laboratory specimens should be placed in durable trays or containers for safe transport.

Biosafety Manual

Standards

- All new employees should read and understand the biosafety manual before working in the laboratory.
- The manual should include information on the standard and the special microbiologic practices appropriate to laboratory Biosafety Level 2.
- Plans for handling various emergencies (e.g., cuts, spills, injuries) should be described in the manual.
- The biosafety manual should be regularly updated.
- Laboratory procedures should be reviewed for compliance with established safety practices by an appointed safety proctor.

Procedures Manual

Standards

- The manual should include step-by-step descriptions of all methods; modifications of procedures should be initialed by the laboratory director.
- The manual should include the criteria for laboratory specimen acceptability.
- Daily quality control records pertaining to test controls and to equipment, temperature, and speed of rotation should be noted in the manual.
- Procedures for quality control checks on new lots of reagents, whether purchased or prepared, should be noted in a special section.
- Instructions for routine and special studies, such as Gram-stained smear versus culture correlation for gonorrhea diagnosis, should be documented in the manual.

0. Disease Intervention Specialist Component

The work performed by disease intervention specialists (DIS) is essential to the successful operation of an STD clinic. DIS reinforce the education/counseling messages provided by the STD clinician during the examination. More importantly, they interview infected patients and perform investigations to locate people who may be at risk for STD and refer them for examination, treatment, and/or HIV counseling. Patient counseling is an integral part of any HIV testing program in an STD clinic. It is appropriate for the DIS to offer a full range of intervention services in a single session rather than ask a patient to repeat the same information to several people. Because STD-related information is sensitive, the patient's transition between clinical care and the

STD interview and/or HIV counseling session must be smooth and appear to be natural extensions of each other.

Standards

- DIS should be on site or on call to provide disease intervention outreach services* during clinic hours.

  * **Where resources are lacking for specialized intervention staff, or work is reassigned based on disease priorities, clinicians and counselors perform intervention services.**

- DIS should thoroughly understand the principles of clinical care and interpretations of laboratory test results.
- DIS should have completed a CDC "Introduction to STD Intervention" course and, if providing counseling about the HIV antibody test, should have completed appropriate instruction in these skills from an instructor using CDC curricula or similar materials.
- Clinic protocols should specify which patients are to receive STD and HIV intervention services from DIS.
- Clinic procedures should promote a smooth exchange of relevant disease intervention information between clinical staff and DIS.
- DIS and clinicians should communicate to ensure consistency in the prevention messages given to patients.
- DIS should be provided with an adequate number of private rooms to ensure that confidential STD interviews and HIV counseling sessions can be conducted without interruption.
- All persons requesting HIV tests should be counseled before they consent to testing and counseled again at the time they receive their results. A signed consent for confidential testing should be obtained before submitting a patient's specimen for testing (oral consent is acceptable for anonymous testing).
- HIV-positive results should be reported only in person and by someone who is trained to discuss the medical, psychological, and social implications of the findings, routes of transmission, and methods of preventing transmission.
- Persons found to have HIV infection should be scheduled or referred for early intervention services, e.g., testing to assess immune system functions, medical evaluation, appropriate therapies to prevent opportunistic infections, and support through systems that facilitate psychosocial adjustment and behavior change.
- Performance* of STD intervention or HIV test counseling should be evaluated for all staff to ensure uniformity of messages.

* **CDC has published prototypes of "Process Performance Standards for Disease Intervention Specialists in STD Control" and "Process Performance Standards for Personnel Performing HIV Disease Intervention (Counseling and Partner Notification)" along with appropriate Skills Inventory formats. Supervisors should use these documents routinely to evaluate staff performance.**

P. Quality Assurance Procedures

Quality assurance is a constructive process that is paramount in implementing patient-care criteria that meet accepted national and local standards. All components of an STD clinic must work together smoothly. Quality assurance provides the opportunity for representatives of all staff to come together to discuss interrelated issues. Peer review and other auditing procedures ensure quality of care and provide an opportunity to give constructive feedback to all staff and administrators. Quality assurance procedures are necessary to detect and correct deficiencies in clinic structure, staffing, equipment, policy, or function. Used as a prevention strategy, quality assurance may ensure the efficient and effective prevention program operation.

Standards

- A quality assurance committee should meet regularly and follow an approved protocol to conduct investigations, analyze findings, and deliver recommendations.
- Medical records should be audited regularly (checked against clinic protocols) to determine the appropriateness of diagnoses and treatment and the completeness of documentation.
- The quality of stat laboratory procedures should be monitored regularly by designing control studies (e. g., Gram stain versus culture correlation of male urethral discharges).
- Staff interactions with patients should be observed regularly (at least every 6 months).
- Semiannual safety audits by an appointed safety proctor should be performed to determine the appropriate use of electrical equipment, storage of chemicals, emergency procedures, and first-aid stations.
- A mechanism should be established for receiving and managing the significant complaints of patients about clinical services which should be thoroughly evaluated.

Guidelines

- The quality assurance committee should comprise the clinic manager, medical director, laboratory director, DIS supervisor, clerical

supervisor, clinical supervisor, and, whenever possible, an outside quality assurance expert.

- Representatives of the finance office and data processing unit should also be included on the quality assurance committee so that they can gain and maintain an understanding of clinic operational needs.

Q. Reporting

Epidemiologic surveillance is the ongoing and systematic collection, analysis, and interpretation of health data in the process of describing and monitoring a health event. Surveillance reporting permits a program to fulfill its mandated function of informing the public about a health problem, and facilitates basic program planning, implementation, and evaluation to determine public health action. Public STD and other health clinics have a particularly important role in case reporting due to the size of the problem in their patient populations. In every state, the law specifies which practitioner or facility is responsible for reporting disease and situations (e.g., child abuse) to the official state agency. Reportable diseases mandated by state laws and included in federal and other voluntary surveillance systems usually include cases of gonorrhea, syphilis, chancroid, lymphogranuloma venereum, and granuloma inguinale. Chlamydia and HIV infection are increasingly reported. Uniform STD surveillance case definitions are vital to the management of disease prevention programs. Case definitions may differ from diagnostic criteria meant to assist the clinician in arriving at a certainty of diagnosis for a given patient and disease. The management of STDs and the suspected sexual abuse of children require close cooperation between the clinic staff and child-protection authorities. Some diseases, such as gonorrhea and syphilis are almost 100% indicative of sexual contact if acquired by children after the neonatal period; in other diseases, such as human papillomavirus infections and vaginitis, the association with sexual contact is not so clear.

Disease Morbidity

Standards

- Clinics should submit morbidity reports promptly following the establishment of a case in the format determined by the state or local prevention program.
- Morbidity reports should be complete, legible, and checked for accuracy before submission.

Guidelines

- The quality assurance of morbidity reports should involve periodic comparison with medical records.
- Computerized medical record systems should be linked to morbidity reporting to expedite rapid data collection.
- Clinic reporting systems should have the necessary safeguards to ensure the proper and nonduplicative reporting of laboratory results and diagnostic determinations.

Sexual Assault and Abuse

Standards

- All clinic staff should be familiar with the provisions of the state child abuse and neglect statute and their obligations under it.
- Clinic staff should also be familiar with applicable STD and HIV confidentiality statutes and should be sensitive to any limitations on the reporting of supplementary information about potential abuse cases.
- The clinic manual should specify the management of patients* of alleged abuse, listing the required examination and proper handling of laboratory specimens for evidence.

  * **Most STD clinicians lack expertise in chain-of-evidence principles and collection of special specimens (e.g., pubic hair or vaginal fluid samples for semen detection). In general, victims of sexual assault or abuse should be evaluated by a provider experienced in these issues.**

- Disease intervention around priority diseases should be initiated promptly.
- Testing of abused or assaulted patients should be performed by the most specific tests available. Culture rather than non-culture tests should be used to detect C. trachomatis, N. gonorrhoeae, and herpes simplex virus.

Guidelines

- Clinics should perform additional confirmatory testing to compensate for the limitations of an individual class of test.
- Clinics should have a patient advocate who maintains links with victim's assistance programs.

The following clinic protocols are presented as a prototype guide to clinical care for which stat testing is available. Since disease prevalence differs in some geographic areas, variations of these protocols may be made following specialized studies and careful consideration of the probability of disease. Many patient evaluation standards are "time honored;" historically, application of the standards has reduced disease prevalence in a population resulting in public health benefit. These standards should not be altered for the sake of individual patient management.

Part II.

Clinic Protocols for Patient Management

A. Patient Evaluation

Information should be collected in a manner which ensures confidentiality, establishes rapport between the patient and clinician, ensures accurate definition of the problem(s), determines levels of risk for HIV, and leads to successful patient management. The clinician must be sure that the patient understands all questions; misunderstandings arise with patients who do not understand English or when scientific terms are used instead of colloquial terms. Sexual history taking is a skill which assists clinicians in determining appropriate tests and treatment. When this is mismanaged, such as failing to provide patients with an appropriate rationale for asking sensitive questions, patients may fabricate "acceptable" sexual histories. This can delay or sidetrack an accurate diagnosis and compromise disease intervention efforts as these inaccurate histories are repeated to DIS.

Medical History

Standards

- The basic STD medical history and risk assessment should be conducted by employing a format of open-ended questions (i.e., beginning with who, what, when, how, how often).
- Clinicians should provide patients with an appropriate rationale for asking sensitive history and risk assessment questions.
- The basic medical history and risk assessment should include:

    1. reasons(s) for the visit
    2. a description of symptoms
        a. onset, duration, character, and frequency
        b. history of similar problems
        c. history of similar or other problems in a sex partner
    3. history of sexually transmitted infections (including HIV), treatment, and dates
    4. medication history
        a. recent antimicrobial use: type, purpose, duration
        b. other pertinent medications, including self-medication: type, purpose, date, and duration
        c. known drug allergy: drug, type of reaction, and date

5. history of blood tests for syphilis and HIV infection, and hepatitis B vaccination: date, place, and result
6. review of general health*
   a. recent pulmonary infections
   b. recent weight loss
   c. unremitting diarrhea

   * **In areas of high HIV prevalence, the general health review should include dry cough, shortness of breath, recurring fevers, night sweats, fatigue, and unexplained diarrhea.**

7. history of drug use and needle-injection practices, including needle-sharing
8. review of recent sexual activity
   a. date of last sexual exposure
   b. number and change of partner(s) in past month*
   c. sites of sexual exposure (oral, genital, anal)
   d. sexual practices (specific practices including men who have sex with men or persons having sex with injection drug users)
   e. use of condoms

   * **Sexual history information, such as number of recent sex partners, should be asked by the clinician only when the potential for making medical decisions exists and when appropriate rationale has been provided. Eliciting and affirming the number of partners is an important step in the disease intervention process and care should be taken so that the acquisition of credible information from the patient is not jeopardized.**

9. for women - reproductive history
   a. date of last menses
   b. unusual aspects of last menses (change in the amount of flow or duration, pain)
   c. type of contraception (with appropriate referrals to family planning, if needed)

Physical Examination

Standards

- The basic physical examination for all patients should include:
  1. general inspection of skin, paying attention to the face, trunk, forearms, palms, and soles and looking for lesions, rashes, and discoloration of the skin (lesions should be well described)
  2. inspection of the oral cavity for lesions and discoloration

3. palpation of the inguinal, femoral, cervical, supraclavicular, epitrochlear, and axillary nodes for lymphadenopathy
4. inspection of pubic hair for lice and nits
5. **for women**
   a. inspection of the external genitalia and perineum for discharge, masses, lesions (which should be well described), and tenderness
   b. palpation of the Bartholin's and Skene's glands
   c. complete pelvic examination
      (1) inspection of the cervix, paying particular attention to the amount, color, and character of any discharge, as well as the presence of ectopy, induced endocervical bleeding, and unusual findings or lesions
      (2) inspection of the vaginal mucosa, paying attention to the amount, color, and character of any discharge, as well as to any lesions
      (3) bimanual examination, paying attention to cervical motion tenderness, uterine enlargement, adnexal tenderness, rebound tenderness, and pelvic masses
   d. inspection of the anus and perianal area
6. for **men**
   a. inspection of penis, paying attention to the meatus, retraction of foreskin, and any discharge from the urethra (the color, amount, and character should be noted)
   b. inspection of the scrotum and palpation of the contents, paying attention to testicular tenderness, size, and masses
   c. inspection of the anus and perianal area of men who have sex with men

Laboratory Testing

Standards

- Routine laboratory specimens for all patients should include:
  1. nontreponemal serologic test for syphilis (STS) at every visit unless a nonreactive test result or a stable low liter result has been recorded within the preceding 30 days
  2. stat nontreponemal antibody card test immediately when unexplained lesion or rash is present and for any sex partner of a confirmed or suspected syphilis patient
  3. darkfield examination* or direct immunofluorescence test of serous fluid for T. pallidum from genital lesion(s) regardless of apparent cause, and non-oral lesions compatible with early syphilis (e.g., papular rash or condylomata lata).

* **While these patients' evaluations require more time, it is extremely valuable to perform darkfield testing while patients remain in the clinic. Darkfield microscopy is the most specific and the earliest indicator of syphilis infection. Rapid diagnosis is the trigger for disease intervention to reduce the incidence of syphilis.**

4. serologic test for HIV
   a. initially, unless a patient reports a test result (reactive* or nonreactive) within the preceding 6 months (in the absence of a recent exposure to HIV infection)

      * **To be reported reactive, the HIV antibody test should include two reactive enzyme immunoassays confirmed by a reactive Western blot or other confirmatory test.**

   b if clinical evidence of syphilis, chancroid, or initial genital herpes has been found
   c. if antibody testing is related to a specific exposure to a person with HIV infection, or following a diagnosis of genital ulcer disease, the test should be repeated 3 and 6 months after exposure
   d. for patients with tuberculosis and for persons for whom a reactive test result might affect the recommended diagnostic evaluation, treatment, or follow-up.
5. for women*
   a. endocervical culture* for N. gonorrhoeae (regardless of point in the menstrual cycle)
      (1) urethral culture if the cervix is absent or if a urethral discharge is present
      (2) anal culture if anus is the site of exposure, or if the endocervix is absent, or if disseminated gonococcal infection is suspected (anal culture or a second endocervical culture will increase the yield of positive results by 3% - 5%)
      (3) oropharyngeal culture if patient has a history of oral exposure or if disseminated gonococcal infection is suspected

      * **The recommended procedure for sequential specimen collection is to (1) collect the vaginal specimen for the saline wet preparation, (2) swab the cervix clean with a cotton pledget; (3) collect the endocervical specimen using a sterile cotton-tipped swab, roll the swab on a clean microscope slide for Gram stain, then roll the swab in a "Z" fashion on the gonorrhea culture plate; then (4) collect the endocervical specimen for chlamydia testing with the appropriate sampling implement.**

b. endocervical Gram-stained smear* for N. gonorrhoeae in women who have cervicitis or who are sex partners to men diagnosed with gonorrhea. Gram-negative intracellular diplococci provide immediate evidence of gonococcal infection. Smears, which are highly specific (95% - 100%) but low in sensitivity (50% - 70%), can be used as an adjunct to, but not a substitute for culture.

* **Additionally, clinics in areas of high prevalence or in areas when studies show a high yield by testing all women, and in correlation testing activities, may decide to perform an endocervical Gram stain routinely.**

Not recommended are:

(1) oropharyngeal smears which contain other microorganisms similar to the gonococcus

(2) rectal smears which are not sensitive unless a purulent discharge is present

c. endocervical diagnostic test* for C. trachomatis regardless of the point in the menstrual cycle (Optional testing includes a urethral culture if the cervix is absent or if a urethral discharge is present.)

* **Of the criteria used to diagnose cervicitis, there is uncertainty about which criteria most accurately predicts cervicitis caused by C. trachomatis. The presence of >30 white blood cells (WBCs) per oil immersion field in combination with induced cervical bleeding and presence of yellow mucopurulent endocervical exudate on a white cotton-tipped swab (positive swab test) are suggested criteria.**

d. tests of vaginal discharge:
(1) "whiff test" (potassium hydroxide [KOH] amine odor test) and pH (>4.5) common to bacterial vaginosis
(2) saline wet mount for T. vaginalis and clue cells associated with bacterial vaginosis and yeast
(3) KOH (10%) wet mount for yeast if saline wet mount is nonreactive and candidiasis is suspected
(4) Gram stains which may also provide evidence of trichomonas, yeast, and the clue cells of bacterial vaginosis

6. for men
   a. urethral culture* for N. gonorrhoeae
      (1) oropharyngeal and anal cultures if the history indicates exposure or symptoms, or if disseminated gonococcal infection is suspected

      * **In instances when treatment for antimicrobial-resistant gonorrhea is not administered, culture urethral and oral sites (anal if site of exposure) if the person is a sex partner to someone infected with antimicrobial resistant N. gonorrhoeae, has recently traveled to an endemic area, is a treatment failure, or gives a history of contact with prostitutes.**

   b. urethral Gram-stained smear for N. gonorrhoeae, with or without symptoms. Observation of gram-negative intracellular diplococci provides immediate evidence of infection. Urethral smears in symptomatic men are highly specific (95%- 100%)and highly sensitive (95% - 98%). Urethral smears in asymptomatic men are less sensitive.

Not recommended are:

(1) oropharyngeal smears which contain other microorganisms similar to the gonococcus
(2) rectal smears which are not very sensitive, unless a purulent discharge is present

   c. Urethral diagnostic test* for C. trachomatis

      * **Some clinicians use the presence of $\geq$5 WBCs per oil immersion field and the absence of intracellular gram -negative diplococci as diagnostic criteria for nongonococcal urethritis of which 30%-50% is caused by C. trachomatis.**

Guidelines

- Additional laboratory testing for STD diagnosis includes:

  1. for all pregnant women during the first trimester: STS, N. gonorrhoeae culture, test for C. trachomatis, hepatitis B test, and HIV counseling and test offer
  2. for all pregnant women in the third trimester at high risk for infection: repeat STS, N. gonorrhoeae culture, C. trachomatis, and hepatitis B test
  3. CD_4+ cell and lymphocyte counts

4. other STDs.

- Supplemental testing includes:

1. Mantoux tuberculin skin test (or referral for testing) for persons with HIV infection* or with risk factors for HIV infection (e. g., injection drug users) and whose tuberculin status is unknown

*** Note: Persons who previously tested tuberculin skin test positive should not be retested.**

2. serologic test for hepatitis B core antibody (if nonreactive, vaccine is recommended) for gay or bisexual men, health care workers, heterosexuals who have had multiple sex partners in the preceding 6 months, and injection drug users
3. Pap smear or referral for Pap smear if not done within past year or if most recent Pap smear was abnormal. Pap smear may also be helpful in identifying herpes simplex virus and human papillomavirus infections.
4. pregnancy test for suspected pregnancy triggers other STD screening and referral for prenatal care

B. Patient Management of STD

Decisions about a patient's disease stage and treatment plan should be based on optimal standards of care.

Guidelines

- After appropriate history, physical examination, and laboratory testing, clinicians should refer "STD Diagnosis/Treatment Guidelines 1993" when planning treatment and follow-up.

C. Medical Consultation and Referral

Persons commonly arrive at STD clinics with conditions that require care by a physician or specialist. The history and examination of patients often indicate a need for health services that are beyond the scope of the STD clinic. This need will vary with the sophistication and expertise of the clinicians. Consequently, nonphysician clinicians occasionally need additional medical consultation and an efficient referral system to ensure that patients receive appropriate care. Community referral systems are also a critical component of the registration system when it is necessary to triage patients for same-day care. Explicit referral instructions should be written into the clinic protocols.

In urgent situations, telephone calls to health care providers can facilitate patient management. In other situations, appointments may be arranged or patients may be given written referrals for additional medical evaluation.

Standards

- The clinic should maintain a current list of community referral resources, including medical specialists (family practitioners, obstetrician-gynecologists, urologists, pediatricians, internists, dermatologists, surgeons, proctologists), family planning clinics, free clinics, hospitals, mental health centers, local emergency medical services, HIV/AIDS agencies, social services, substance abuse treatment centers, and religious institutions.
- Patient referral systems facilitating triage may include providing the patient with:

    1. a list of community health resources within natural geographic boundaries including hours, addresses, and telephone numbers
    2. a list of community physicians or medical facilities with an interest in STD patient management
    3. the next name on the list of community medical care givers

- Physician consultation is usually indicated when:

    1. pelvic examination cannot be conducted satisfactorily
    2. other pelvic examination abnormalities (e.g., uterine enlargement, adnexal masses) are found
    3. acute salpingitis is diagnosed in a pregnant patient
    4. first-episode genital herpes lesions are found in a pregnant patient
    5. Bartholin's glands are tender or enlarged
    6. testicles are painful or tender
    7. the diagnosis is uncertain, or disease is severe
    8. serious sign of adverse reaction to treatment occurs, such as anaphylaxis (angioedema, urticaria, bronchospasm, hypotension, pruritus), procaine reaction (seizures, psychosis, mania), Jarisch-Herxheimer, skin rash, or anxiety (hyperventilation, fainting, distal paresthesia)
    9. local regulations dictate
    10. the needed STD treatment or procedure is not specified in the standing orders

Guidelines

- Patient referral to a specialist may be indicated when:

  1. a patient with HIV infection needs medical evaluation and treatment
  2. a patient with acute salpingitis is believed to need impatient care (see STD Diagnosis/Treatment Guidelines)
  3. a pregnant patient* is not receiving prenatal care

     * **Pregnant patients who are infected with, or who are sex partners of patients with STDs, should be treated <u>while in the STD clinic</u> (unless recommended medication is contraindicated in pregnancy) and then referred for prenatal care.**

  4. a woman who is sexually active but who uses no contraception requests contraception services or asks about sterilization
  5. intrauterine device (IUD) removal is medically necessary
  6. symptoms suggesting a urinary tract infection seem to recur
  7. urethritis does not respond to medical therapy
  8. other urologic and prostatic disorders are recognized
  9. a general surgical evaluation is needed for such findings as an inguinal hernia, hemorrhoids, testicular varicocele or atrophy, or extensive warts
  10. a severe drug reaction requires further treatment or observation
  11. pregnant patients who have syphilis need penicillin allergy skin testing and desensitization
  12. a patient is found to have hepatitis B virus infection
  13. a tuberculin skin test is found positive

Option

- Contraceptive services, including counseling and dispensing of birth control pills, and pregnancy testing should be available at the facility which is providing STD services.

D. Follow-Up to Therapy

Ensuring that a patient is cured of diagnosed infection is an important aspect of STD intervention. When a patient is noncompliant or therapy fails, patients may still transmit infection. Follow-up protocols are influenced when recommended treatments change. Increased use of new and efficacious antimicrobials in the dual therapy of gonorrhea has eliminated the need for routine test-of-cure. Quality counseling regarding treatment compliance, treatment failure, and follow-up examinations minimize the potential for disease

transmission. Since most patients returning for follow-up exam have experienced the complete examination and counseling process and need only their blood drawn or lesions checked, their visits are usually short (e.g., 5-10 minutes).

Standards

- Patients returning for follow-up exams should be "fast-tracked" into the clinic system.
- Follow-up history should include:

    1. changes in symptoms
    2. adverse reaction to drugs: allergic, Jarisch-Herxheimer, gastrointestinal
    3. compliance with instructions
    4. sexual exposure since therapy, including question of condom use
    5. treatment status of partner(s)

- Physical examination should include any new complaints and a reevaluation of the earlier examination
- Laboratory tests designed for tests-of-cure or antimicrobial sensitivity, when indicated (see STD Diagnosis/Treatment Guidelines).

E. Counseling/Education

Patient counseling and education, which are designed to influence STD intervention and prevention behaviors, must be undertaken by both DIS staff and clinicians. Protocols should contain specific messages about reducing the risk of HIV infection for all STD clinic patients, regardless of their antibody status. In an STD clinic, these messages can and should be combined because most prevention measures apply to HIV infection and most other STDs. Even clinicians who are not formally conducting HIV antibody test counseling have the opportunity before the pretest counseling session to motivate patients to accept the test. Handouts and video presentations are an efficient way of giving patients basic information; but the only way to ensure that patients understand a condition and their role in its management is through active patient counseling. On occasion, patients may have complicated behavioral problems that are beyond the skills of the STD clinic staff: for example, patients with multiple episodes of STDs (repeaters) who have a disproportionately high rate of STDs; and, multiple drug users who have a high proportion of HIV infection.

Standards

- The clinic staff should stress the value of medical evaluation and partner notification and ensure that the patient understands:

  1. the name of the disease, how it is transmitted, the incubation period*, the role of asymptomatic infection, and the infectious period

     * **If patients are diagnosed with priority STDs and DIS are available, clinicians should defer to DIS for discussions with patients about incubation and infectious periods. DIS often have more comprehensive information about related cases. Patients who attempt to interpret this information and their place in the chain of transmission, often omit selected exposure information to DIS, thereby contributing to loss in disease intervention.**

  2. how the disease is diagnosed
  3. potential complications in the patient and partner(s)
  4. the necessity for sex partner(s) to seek medical care from a provider or facility offering appropriate STD care

- Since reinfection can occur easily, risk reduction messages should include:

  1. avoiding sex until partners have been examined and are free of disease, and patient has completed therapy and symptoms have resolved
  2. results and interpretation of all tests (e.g.,a nonreactive test result does not necessarily mean the absence of infection)
  3. abstinence, or monogamy with an uninfected partner
  4. use of condoms and other safe sex practices

- Messages should stress that if symptoms recur or another STD is suspected, patients should stop having sex and seek care promptly.
- When medication is provided, patients should understand:

  1. names of the medications and why they are used
  2. how and when to take "take-home" medication and the expected outcome of treatment
  3. what to do if medication is missed or if side effects occur (e.g., taking tetracycline on an empty stomach, the interaction of metronidazole and alcohol)
  4. that, by sharing medication with other people or by not taking all the medicine, symptoms may be masked or laboratory tests may

not provide accurate results, thus making diagnosis difficult for the clinician

- If follow-up examinations are scheduled, patients should be counseled concerning:

  1. the need for follow-up tests and the clinic procedure for appointments and expedited follow-up care
  2. potential health consequences of not obtaining the tests

- Handouts should be of two basic types:

  1. general handouts for patients to read before their diagnosis to reinforce the messages from the clinic staff
  2. disease-specific and treatment-specific handouts to reinforce verbal explanations of diseases, treatments, plans for follow-up (available in examination rooms for clinicians to give to patients after diagnosis)

- In additional HIV risk-reduction counseling messages, all patients should be advised to:*

  * **The Comprehensive AIDS Resources Emergency Act of 1990, also called the Ryan White CARE Act, authorized the allocation of federal funds by formula for providing HIV-related services. Recipients of funds are required by the Ryan White CARE Act to provide or arrange early intervention services for persons found to be infected with HIV. HIV risk-reduction messages are specifically delineated in the Ryan White CARE Act.**

  1. avoid the parenteral use of illegal drugs, sharing of needles, and use of unsterilized injection equipment
  2. abstain from sex with persons known to be or suspected of being infected with HIV* or at risk for HIV or other STDs

     * **Having sex with needle-sharing drug users, multiple sex partners, or individuals with numerous casual partners greatly increases the risk of HIV infection.**

  3. seek testing upon entering a mutually faithful monogamous relationship, if past behavior has increased the risk for HIV infection
  4. be aware that anal intercourse is the sexual behavior with the highest risk for HIV transmission
  5. use latex condoms if one chooses to continue having multiple sex partners or plans to initiate new relationships. Fisting and anal

intercourse with multiple partners are strongly discouraged, regardless of condom use.

- Additionally, patients should understand:

  1. the mental effects resulting from abuse of drugs may decrease one's concern about risk reduction
  2. any man who has had sex with another man or injected drugs since 1977 should not donate blood, plasma, semen, or organs for transplant. This also applies to men who have had only a single insertive or receptive episode of anal intercourse and who do not consider themselves homosexual or bisexual.
  3. that women of childbearing age who are at increased risk for HIV infection, including exposure to, or infection with STDs, should be counseled on the use of condoms, tested for HIV antibody, and informed about reproductive options. Included in the high-risk category are women who have been injection drug users at any time since 1977, women whose sex partners were injection drug users or who had sex with other men, and sexually active women who live in areas with a high HIV seroprevalence and incidence of AIDS.
  4. persons with HIV infection should be counseled about the risks of sexual and perinatal transmission; all partners should be referred for HIV antibody testing

- The STD clinic should develop links with drug treatment and outreach community programs (e.g., support groups, peer counseling), and professional counselors to effectively refer patients who need special services such as drug or crisis counseling.

F. Management of Sex Partners

Breaking the chain of transmission is crucial to STD prevention. Further transmission and reinfection are prevented by referring sex partners for diagnosis and treatment. The referral function targets not only those persons who may have transmitted infection, but also those who may have been exposed to the patient after acquiring the infection. Exposure periods have been determined for most STDs as the periods during which it is likely that sex partners may be incubating the disease. Once infected, the sex partners are capable of transmitting the infection to others and are at risk for disease complications. Depending on clinic policies, patients may self-refer their own sex partner(s) or a DIS will confidentially locate partners at risk.

Standards

- Persons verified as partners of infected patients who were exposed during established disease intervention intervals should be offered therapeutic or preventive treatment.
- All partners of patients with STDs requesting examinations should be evaluated according to medical protocols and, if needed, given therapeutic or preventive treatment.
- Rarely is it appropriate to treat a person without a thorough medical evaluation (e.g., sending medications with patients for sexual partners).
- Preventive treatment should be given unless the patient's circumstances and drug allergy history clearly suggest that the risks of therapy outweigh the risks from possible infection.

Equipment and Supplies for STD Examination Rooms

A. Furniture

1. Examination table with stirrups
2. Sink with water source
3. Writing table
4. Patient chair/phlebotomy chair
5. Clinician chair (swivel type)
6. Supply storage cabinet

B. Physical Exam Equipment and Supplies

1. Vaginal specula (stainless steel or disposable; small, medium, and large sizes in ratio of 1:5:1; also Pederson/virginal type)
2. Anoscopes (stainless steel or disposable)
3. Examination lamp (moveable arm type)
4. Magnifying glass
5. Forceps (small straight and ring type)
6. Flashlight with fresh batteries
7. Oral thermometer
8. Stethoscope
9. Sphygmomanometer
10. Otoscope/ophthalmoscope
11. Gloves (disposable, various sizes)
12. Tongue depressors

C. Specimen Collection Supplies

1. Scalpel and # 11 blades
2. Glass slides (1" x 3" with frosted end; 1.15-1.25 mm thickness for darkfield microscopy)
3. Coverslips (1" x 1")
4. Gauze pads (sterile, 2" x 2" or 4" x 4")
5. Cotton balls
6. Adhesive tape
7. Isopropyl alcohol
8. Tourniquets
9. Blood collection tubes ("red top", evacuated, nonsterile, various sizes)
10. Blood collection tube holders
11. Test tube rack
12. Venipuncture needles (20/21 gauge; 1 ½ in.)
13. Syringes (5 ml)
14. Needles (18, 21, 23 gauge)

15. Urine specimen containers
16. Cotton-tipped applicators (sterile)
17. Calcium alginate swabs (sterile)
18. Large diameter cotton-tipped swabs
19. Sterile lubricant
20. Test tubes (13 mm x 100 mm)
21. Bacterial loop and source for heat sterilization
22. Potassium hydroxide (KOH) 10% solution
23. Normal saline (sterile)
24. Culture plates with a recommended selective medium for gonorrhea (Martin-Lewis, Modified Thayer-Martin, or New York City media)
25. Candle jar with candle and matches or special plastic bags with carbon dioxide generating tablets

D. Miscellaneous Supplies

1. Examination table paper
2. Disposable paper sheets and/or patient dressing gowns
3. Paper towels
4. Soap
5. Sanitary napkins and tampons
6. Bandaids
7. Discard container for disposable sharp instruments (leak-proof, puncture -resistant)
8. Trash can
9. Contaminated-waste-collection container
10. Mirror with handle
11. Mantoux skin test ruler
12. Wooden spatula (for Pap smears)
13. Commercial aerosol fixative (for Pap smears)
14. Anatomic models or pictures
15. Educational materials
16. Laboratory test reagents
17. Emergency equipment

Equipment and Supplies for Stat Laboratory

A. Furniture

1. Laboratory benches with impervious tops
2. Chairs (comfortable for sitting for long periods)
3. Sink for handwashing near door
4. Supply storage cabinet
5. Trash can

B. Equipment

1. Brightfield microscope (binocular; 10x, 40-45x, and 100x oil immersion objectives; 6.0 to 6.5-volt high-intensity lamp, as light source)
2. Darkfield microscope (binocular, with eye cups; 10x, 40-45x, and 100x oil immersion objective with iris diaphragm or funnel stop; tungsten light source with 6.0 to 6.5-volt intensity; darkfield condenser)
3. Centrifuge (table-top, with safety cover)
4. Biological safety cabinet (Class I or Class II - Optional, if safety centrifuge is used)
5. Refrigerator (4 - 8°C)
6. Incubator (35 -37°C)
7. CO_2 incubator or candle jar
8. Rotator (100 rpm with timer and humidifier cover for nontreponemal antibody card tests)
9. Automatic pipetting devices
10. High-intensity lamp for reagin card tests
11. Bunsen burner or alcohol lamp
12. Thermometer (0-100°C)

C. Reagents

1. Physiological saline solution (0.9%)
2. Potassium hydroxide solution (KOH 10%)
3. Gram-stain reagents
   - Crystal violet
   - Gram's iodine
   - Decolorizer (alcohol - acetone)
   - Safranin
4. Gonorrhea culture media (Selected medium, e.g., Modified Thayer-Martin plates, Martin-Lewis plates)
5. Urine test strips for leukocyte esterase test
6. Nontreponemal antibody card test kits (cards, antigen, disposable pipettes, and antigen dropping bottle with needle)

7. Control cards for nontreponemal antibody card tests
8. Chlamydia diagnostic tests
9. Tzanck stain (Wright-Giemsa)
10. Pregnancy test

D. Test Supplies

1. Slides (1" x 3"with frosted end; 1.15-1.25 mm thickness)
2. Coverslips
3. Immersion oil
4. Blotting paper
5. Staining trays
6. Moisture chamber
7. pH paper
8. Mineral oil
9. Swabs (cotton)
10. Sterile wire loop (disposable or nondisposable)
11. Glass tubes (13 mm x 100 mm)
12. Test tube racks
13. Disposable pipette tips

E. Biosafety and Miscellaneous Supplies

1. Gloves
2. Lab coats
3. Masks/face shield
4. Biohazard bags
5. Discard pans (seamless, puncture-proof, with fitted lids)
6. Microbiologic disinfectant
7. Bleach
8. China markers
9. Non-water-soluble fin-tipped markers

F. Additional Testing Supplies

1. Available from reference laboratory
   - as in cultures for chancroid, herpes, trichomonas, chlamydia
   - HIV antibody (EIA, Western blot)
   - STS (FTA-ABS, MHA-TP)
   - enteric cultures
   - parasite microscope
   - Hepatitis B serologic testing
   - CD_4+ testing
2. Pap smear

Emergency Care Equipment, Supplies, and Medications

Local practices may dictate the use of alternative emergency care equipment, supplies, and medications. Please consult local emergency care experts and coordinate emergency preparedness with the local emergency medical system. A current emergency care plan should be included in the clinic procedures manual.

A copy of the inventory is to be kept on top of the crash cart. All equipment should be tested periodically; the date and the results should be recorded.

A. Equipment

1. Crash care or emergency kit (with portable IV hanger)
2. AMBU bag
3. Oral airways (1 medium, 1 large)
4. Oral bite blocks (2)
5. Sphygmomanometer
6. Stethoscope
7. Flashlight
8. Oxygen tank or compressed air tank with regulator mask
9. Endotracheal tube

B. Supplies

1. Tourniquets
2. Syringes (1 cc and 5 cc; 4 each)
3. Intravenous infusion sets with flexible tubing (at least 2)
4. Intravenous catheter placement units (17 gauge and 19 gauge; 2 each)
5. Gauze pads (4" x 4")
6. Adhesive tape
7. Flashlight batteries

C. Medications (Check expiration date periodically)

1. Aqueous epinephrine (1:1000; 1 cc ampules; at least 4; more for medically isolated clinics)
2. Aminophylline (500 mg ampules; 2 each)
3. Dextrose 5% in water; 500 cc; 2 each
4. Diphenhydramine hydrochloride (10 mg/ml; 10 cc vial; 2 each)
5. Hydrocortisone sodium succinate (500 mg ampule; 2 each)
6. Norepinephrine bitartrate (4 mg ampules; 2 each)
7. Normal saline (1,000 ml bottle; 2 each)
8. Smelling salts or ammonia ampules (Optional)

Patient Information Handouts

Providing patient information sheets or pamphlets to patients when they enter the clinic can reduce anxiety, expedite clinic flow, and increase the quality of services provided. Patients should know from the beginning what to expect during their clinic visit. All educational materials should be written at the educational level of the population served (usually 8th grade), and in terms they can understand. For the facility that needs to develop a pamphlet, the following important information should be included:

1. Name and address of clinic
2. Telephone number and hours of operation
3. Any fees for services or medications
4. An assurance of confidentiality
5. The registration process
6. Clinic flow
7. The examination procedure
8. Facts about diagnosis and treatment
9. The need for follow-up
10. HIV testing and counseling
11. Sex partner notification
12. Invitation to ask questions

Metro City Health Center STD Clinic

1250 12th Avenue
Telephone 727-5000

Hours of Operation: Monday, Wednesday, Friday, 8:00 a.m. to 4:30 p.m.
Tuesday, Thursday, 11:00 a.m. to 7:30 p.m.

Welcome to the Sexually Transmitted Disease (STD) Clinic. The information below will answer many of your questions. Our staff is here to serve you and will provide additional information. All services are provided free of charge by the state and Metro City. The patient information form you were given to complete will be used to make up your medical record. Please be sure to include your current address and telephone number. If we need to contact you about your test results, it is very important that we be able to do so. Everything contained in your medical record is confidential. No information will be released without your written consent. After you have completed this form, you will be given a number and asked to have a seat. All patients who arrive during clinic hours will be seen. If you did not make an appointment, some patients who arrived after you will be called ahead of you. Your patience while waiting is greatly appreciated.

The clinician will call you by your number, not your name. Numbers are not always called in order. You will see a licensed medical examiner. Blood may be drawn from your arm to be tested for syphilis and HIV infection. The clinician will then do a brief examination of your genitals. If a discharge is present, an immediate examination of the discharge under the microscope may be possible. The results take only a few minutes, but all other test results may take several days.

Treatment will be given for some infections during this visit. For other infections, treatment will be delayed until we receive the test results from the laboratory. You may be asked to wait 20-30 minutes before leaving the clinic if you were given an injection. Please do so. This is to make sure you do not have a bad reaction to the medicine. If you are given medicine to take home, make sure you understand how to take it before leaving. Your symptoms may disappear before you finish your medicine. This is a sign that the medicine is working, but to be completely cured, you must finish all the medicine. Do not share your medicine with anyone. You will not be cured, and it is dangerous for another person to take medicine that was not ordered for that person. After your examination is completed, you may be referred to another member of the clinic staff, who will discuss your infection with you in more detail and answer any of your questions. You may be asked to call for your test results. You may obtain your own--only your own--test results by calling 727-5000, 8:00 a.m.- 10:00 a.m., Monday-Friday.

THIS CLINIC IS HERE TO SERVE YOU. We need your help to serve you in the best way possible. Please let us know how we can improve our services to you.

Instructions for Condom Use

1.	Latex	Use latex condoms rather than natural membrane condoms. Latex reduces the likelihood of breakage or leakage, and are non-permeable.
2.	Storage . . .	Store condoms in a cool, dry place, out of direct sunlight
3.	Damage . .	Do not use condoms that appear damaged or old.
4.	Handling . .	Handle condoms with care to prevent puncture.
5.	Before Use	Before any genital contact, put the condom on by holding the tip and unrolling it onto the erect penis, leaving space (but not air) at the tip to collect semen.
6.	Lubrication	Use adequate water-based lubrication; petroleum jelly or oil-based lubricants will weaken the latex.
7.	Spermicide	Spermicide may provide additional protection; vaginal use is likely to provide greater protection.
8.	Breakage . .	If a condom breaks, replace it immediately. The efficacy of post-ejaculation spermicide is unknown.
9.	After Use .	To reduce the chance that the condom will slip off after ejaculation, hold the base of the condom while withdrawing and withdraw while the penis is still erect.

Prevention is the most effective strategy for controlling the spread of infectious diseases. Prevention through avoiding exposure is the best strategy for controlling the spread of STDs. Behavior that eliminates or reduces the risk on one STD will likely reduce the risk of all STDs. Proper use of condoms during each act of sexual intercourse can reduce, but not eliminate, risk of STDs. Persons likely to become infected or known to be infected with HIV should be aware that condom use cannot completely eliminate the risk of transmission, to themselves or to others.

For the wearer, condoms provide a mechanical barrier that should reduce the risk of infections acquired through penile exposure to infectious cervical, vaginal, vulvar, or rectal secretions or lesions. For the wearer's partner, the proper use of a condom should prevent the depositing of semen, contact with urethral discharge, and exposure to lesions on head or shaft of the penis. For infectious agents spread from lesions rather than fluids, condoms may offer less protection because areas of skin not covered by the condom may be infectious or vulnerable to infection.

Condoms are not always effective in preventing STDs. The failure of condoms to protect against STDs is probably explained by user failure more often than by product failure. User failure includes failure to 1) use a condom with each act of sexual intercourse, 2) put the condom on before any genital contact occurs, or 3) completely unroll the condom. Other user behaviors that may contribute to condom breakage include inadequate lubrication; use of oil-based lubricants which weaken latex; and inadequate space at the tip of the condom.

Product failure refers to condom breakage or leakage due to deterioration or poor manufacturing quality. Deterioration may result from age or improper post-manufacturing storage conditions.

The active ingredients in commercially available spermicide have been shown in the laboratory to inactivate sexually transmitted agents, including HIV. The use of vaginal spermicide is associated with a lower risk of gonorrhea and chlamydial infection. The use of spermicide-containing condoms may further protect against STDs in the event of condom leakage or seepage. However, the spermicidal barrier would no longer be in place if the condom broke. If extra protection is desired, vaginal application of spermicide is likely to afford greater protection than the use of spermicide in the condom because a larger volume of spermicide would already be in place in the event of condom breakage. Neither the safety nor the efficacy of spermicide in preventing sexually transmitted infections of the anal canal or oropharynx has been studied.*

* U.S. Department of Health and Human Services, Public Health Service. Condoms for Prevention of Sexually Transmitted Diseases MMWR 1988 (March 11); 37(9): 133-137.

Combination Appointment and Walk-In Registration Systems

System Characteristics:

Registration systems have the potential to influence the effectiveness of the clinical operations and contribute to the quality of patient services. No set formula or calculation for the establishment of a combination appointment and walk-in system is feasible. Each clinic possesses individual characteristics based on location, patient census, the population at risk, disease prevalence, and clinic flow. Other critical considerations include the ratio of staff to patients, clinician skill level, and clinical training responsibilities. The following guidelines for establishing a combination STD clinic appointment and walk-in registration procedure are compiled from the shared experiences of facilities that have piloted such systems. After carefully studying the issues, any system should be designed to be flexible enough to accommodate the variables in attendance which can change daily.

Purpose:

Many STD clinics without some appointment system each day experience the "Monday Morning Syndrome." That is, the number of patients who can be examined during the entire clinic day are assembled to register when the clinic opens. Over the past 10 years, the general STD examination has become increasingly comprehensive. It now includes evaluation for cofactors to HIV-infection, evaluation for pelvic inflammatory disease, diagnosis of common vaginitis, management of genital warts, testing for gonococcal antibiotic resistance and chlamydia, and HIV risk prevention counseling. Additionally, patients are more informed about STDs and ask more questions. Patients come to the clinic for medicine for their discharges and lesions unsuspecting of additional disease intervention activities planned for them. With an adequately managed system, patients should experience reduce waiting times and triage for same-day service. This will affect their compliance and willingness to return. In addition, clinicians should be able to provide higher quality services and maintain attention to disease priorities.

Determining the Appointment Schedule:

1. Only same-day appointments are available.
   Exception: DIS assign same-day or next-day appointments in the field. DIS may telephone the registration clerk for time slots or record assigned appointments on the clinic schedule prior to daily registration.

Note: Many clinics find the "no-show" rate for same-day appointments to be approximately 20%. Transportation problems are given as the major factor. The "no-show" rate for next-

day appointments is 50%; patients often seek medical care elsewhere and do not cancel appointments.

2. The number of appointments is determined by predicted staffing. Appointments are scheduled in 30 minute intervals for adequate examination of genital ulcers and abdominal pain.

3. The appointment registration window opens 30 minutes before the clinic opens and remains open until all appointments available for the day are filled (average 2 hours).

Note: It is advisable that several telephone lines be linked to the registration clerk. Callers can be placed on "hold" and know they will be served rather than hear a "busy" signal.

4. Registration clerks assign same-day appointments only and record patient names in the appointment book (15 second activity per caller). If the clinic is not fully staffed, registration clerks triage callers (2 minute activity).

   Triage selects out people with no STD problem and those with disease priorities. If appointment slots are limited, other callers with nonpriority STD-related problems are referred to other health agencies and encouraged to be seen that day and informed to call back the next day if still in need of examination. Triage questions include:
   a. What is the problem? (ulcer, rash, open sore, females - abdominal pain)
   b. Females - Are you pregnant?
   c. Who told you to come in? (notified by partner diagnosed with STD)

Managing Walk-in Services:

1. Walk-in patients are given any appointments remaining on the appointment schedule.

2 If appointments are filled, walk-in patients are evaluated by a triage clinician. Patients should be evaluated in private (5 minute activity).

Note: Due to the expected "no-show" rate, 20% of clinic time will be available for priority walk-in clients.

Triage questions include:
   a. What is the problem? (ulcer, rash, open sore, females - abdominal pain)
   b. Females - Are you pregnant?

c. Who told you to come in? (partner notification)

3. Walk-ins routinely worked into the schedule are:
   a. All DIS referrals.
   b. Follow-up lesion checks such as chancroid, or repeat syphilis serology (5-10 minute activity).
   c. Females - due to complication of disease.
   d. Patients with lesions or suspected of having infectious syphilis or chancroid.

   Walk-in patients ineligible to be worked into the system are given the option of calling the next morning during registration for an appointment or of accepting a referral to a community medical facility. These patients are given a list of resources that include local emergency rooms, community health centers (some patients have insurance), cooperating community physicians, lists of physicians by area of the city, family planning clinics.

4. Patients determined by triage to need same-day examination return to the registration window for a number (but not an appointment time). Registration clerks keep an accounting of walk-in patient waiting for examination in the appointment book. Numbers are called during appointment times of "no shows." (Average waiting time 1 - 2 hours)

Calculation for Number of Clinicians for Clinic

For efficient patient flow and disease intervention, clinics should be adequately staffed to manage all patients needing medical care each day. This calculation assumes that with a combination walk-in/appointment system, patients will present at a constant rate. Clinics that experience a backlog of patients waiting to be examined should also evaluate the clinic hours of operation, registration practices, disease prevalence, and counseling needs of patients. Patients with genital ulcer disease usually require increased examination time and disease risk counseling.

Data Needed

X = estimated time spent with male patient by clinician expressed as a fraction of an hour; example: 20 minutes = .33 hr.
Y = Estimated time spent with female patient by clinician expressed as a fraction of an hour; example: 30 minutes = .5 hr.
A = total number of male patients examined/day
B = total number of female patients examined /day
C = total clinic hours/day
D = total hours/day of break time and lunch time

Calculation

X x A = total male utilization time
Y x B = total female utilization time
(X x A) + (Y x B) = total patient utilization time
(X x A) + (Y x B) / C - D = total clinicians needed/day

Example

Metro clinic provides service to approximately 300 patient per week (60 patients per day, 40 male, 20 female). Clinic is open 8 hours continuously each day from 8 a.m. to 4 p.m. on Monday, Tuesday, Thursday, Friday and from 11 a.m. to 7 p.m. on Wednesday.

X = .33
Y = .5
A = 40
B = 20
C = 8
D = 1.5

(.33 x 40) + (.5 x 20) / (8 - 1.5) = 3.57 clinicians*

*** In reality, the need would be 4 clinicians to provide continuous coverage over breaks and lunches.**

Criteria for Chart Audit

Clinic:_____

Evaluator:_____ Date Evaluated:_____

Clinic Manager:_____ Date Reviewed:_____

Medical charts should be reviewed routinely to ensure the quality of the medical management of STD patients. This form can be used for recording several chart audits on STD patients. For each item, place a check in the appropriate column.

STANDARD
1 = Needs improvement
2 = Satisfactory
3 = Excellent

	1	2	3
REGISTRATION			
1. Name, address, telephone number of the patient			
2. Date of birth, race/ethnic origin, marital status, sex			
3. Emergency locating information			
MEDICAL HISTORY			
1. Reason(s) for visit			
2. Description of symptoms (current symptoms, similar problems, or STD in sex partner)			
3. History of STD or HIV (treatment, dates)			
4. Review of medication history (antibiotics, allergy, other)			
5. Review of blood donation, transfusion			
6. Review of blood tests for syphilis and HIV (date, result)			
7. Review of general health			
8. History of drug use and needle-sharing			
9. Review of sexual activity (last exposure, number of partners, orientation, exposure sites, condom use)			
10. Women - Reproductive history (menses, contraception)			
PHYSICAL EXAMINATION			
1. Inspection of skin (lesions, rashes, lymphadenopathy, discoloration)			

	1	2	3
2. Inspection of oropharynx (lesions and discoloration)	/	/	
3. Palpation of inguinal, femoral, cervical supraclavicular, epitrochlear, and axillary lymph nodes	/	/	
4. Genital - Women:			
- inspection of external genitalia (lice, nits, discharge, mass, lesions, tenderness)	/	/	
- palpation of Bartholin's and Skene's glands	/	/	
- inspection of cervix (discharge, ectopy, induced endocervical bleeding, lesions)	/	/	
- inspection of vaginal mucosa (discharge, lesions)	/	/	
- bimanual (cervical motion, adnexal tenderness, mass)	/	/	
- inspection of anus and perianal area	/	/	
Genital - Men			
- inspection of pubic hair (lice, nits)	/	/	
- inspection of penis, meatus, foreskin (discharge, lesions)	/	/	
- palpation of scrotum (tenderness, mass)	/	/	
- inspection of anus and perianal area	/	/	
LABORATORY			
1. Appropriate specimens obtained			
- gram stain (gonorrhea, WBC)	/	/	
- gonorrhea culture(s) (endocervical/urethral, oral, anal)	/	/	
- chlamydia test (endocervical/urethral)	/	/	
- STS (unless nonrective in past 30 days)	/	/	
- HIV antibody (initial visit, genital ulcer, exposure)	/	/	
- Women - tests of vaginal discharge (wet mount, KOH)	/	/	
2. Additional tests from history/physical findings			
- darkfield (lesions)	/	/	
- other STD tests	/	/	
- tuberculosis skin test/referral (if HIV positive)	/	/	
- hepatitis B serologic test (e.g., HBsAg, anti-HBc) or vaccination (gay/bisexual men, health care workers)	/	/	

	1	2	3
- Pap smear or referral (if not done in past year)	/	/	
- pregnancy test	/	/	
- STD tests during first and third trimester	/	/	
DIAGNOSIS			
- Appropriate diagnosis made	/	/	
THERAPY			
- Appropriate therapy provided (STD Diagnosis/ Treatment Guidelines, 1993)	/	/	
COUNSELING/EDUCATION			
1. Partner notification and medical evaluation (disease transmission, complications, sex partner, treatment)	/	/	
2. Risk reduction messages (avoid sex until partners are examined, safe sex, reduce number of partners)	/	/	
3. Response to future disease suspicion	/	/	
4. Medication (name, schedule, side effects)	/	/	
5. Follow-up exam (procedures, consequences)	/	/	
6. Patient handouts (disease- and treatment-specific)	/	/	
7. HIV risk-reduction messages (drug use, needle sharing, HIV testing, condoms, nitrite inhalants)	/	/	
- Men - bisexual/gay since 1977: avoid donations	/	/	
- Women - if infected, delay pregnancy	/	/	
EMERGENCY PRECAUTION			
- Appropriate use of emergency protocol	/	/	
CONSULTATION AND REFERRAL			
1. Appropriate referral to community resource/specialist	/	/	
2. Appropriate physician consulted	/	/	

	1	2	3
FOLLOW-UP			
1. Medical history (symptoms, medication, sexual exposure, condom use)	/	/	
2. Physical exam	/	/	
3. Laboratory tests	/	/	
SIGNATURE			
- Appropriate signature of clinician or others	/	/	

COMMENTS

Procedure for Purging Medical Records

An effective STD prevention program requires that medical records be handled in a manner that ensures 1) protection from unauthorized disclosure and 2) access to recent records. Most states have recognized this exceptional need for confidentiality by enacting sexually transmitted disease confidentiality laws. Clinic procedures for purging STD medical records must be consistent with existing medical record retention laws and regulations. STD records that are not pertinent to future medical care and that exceed the required retention period should be destroyed.

Medical record purging is facilitated by coding medical charts according to diagnosis and the month and year of last visit. Specific information may be assigned to a color tab or number placed on the edge of the record folder. Syphilis records may be color coded to distinguish them from nonsyphilis records. The charts belonging to patients seen during the same year and month should bear the same color or number.

Records entered on computer deserve the same protection from unauthorized disclosure, including limited access to the system by keys or personal user access codes. Although storage is rarely a problem, the system is subject to greater breeches of confidentiality unless purging is routinely performed. To purge, locate records by diagnosis and date of last visit, and copy them to computer disks for storage until destroyed.

Example A (Clinics with record filing codes):

1. At the beginning of each month, the nonsyphilis records for the same month of the previous year are purged.
2. Syphilis records (or records with any reactive syphilis test) are not purged.
3. If patients return to the clinic within a year of their last visit, the month and year code is changed. Thus, a record remains in the active file for one year after the patient's last visit.
4. Purged records are stored away from the main clinic area until the legal retention period expires.

Example B (Clinics without record filing codes):

1. Each year all clinic records should be reviewed.
2. If the last STD visit was less than one year from the date of this review, the record is returned to the current file.
3. All syphilis records (or any other records with a reactive syphilis test) are returned to the current file.
4. Other records (nonsyphilis, older than one year) are purged. Purged records are stored away from the main record area until the legal retention period expires.

Note: Some medical facilities continue to chart STD visits in the same medical record with other non-STD visits. With this system, protecting the records of STD patients from unauthorized disclosure is more difficult.

Clinician Job Description

Position Title: Non-Physician STD Clinician

Position Purpose: Functions in an extended role to provide primary care to patients who have, or are suspected of having, one or more STDs, according to protocols approved by the medical director.

Accountability: Reports to the clinic manager and follows clinic policies and procedures. Clinical skills will be evaluated periodically.

Requirements: Current license or authorization to provide direct patient care under the laws of the state.

Knowledge:

- Thorough knowledge of STDs, universal blood and body fluid precautions, and emergency procedures.
- Understanding of the preparation and maintenance of accurate medical and other clinic records.
- Understanding of the principles of public health services.

Abilities:

- Ability to read, write, speak, and understand English fluently.
- Ability to work harmoniously with associates.
- Ability to analyze, comprehend, interpret, and apply clinic principles, procedures, and practices to specific cases.
- Must be able to effectively and efficiently perform examinations.
- Willingness to examine patients regardless of race, origin, gender, or sexual orientation.
- Must be comfortable with periodic evaluations of clinical skills.

Principal Responsibilities:

1. Establish rapport with the patient to facilitate communication and elicit accurate sexual and disease history.
2. Provide direct care to patients and thoroughly examine the appropriate anatomy, including bimanual and testicular exams, evaluation of oropharyngeal cavity and skin, and palpation of lymph nodes.
3. According to approved procedures, collect and label patient specimens for laboratory determination.
4. Consult with clinic physician according to the clinic guidelines about patients with diagnostic problems, complications, or any medical circumstance not covered in the written protocol.
5. Determine the diagnosis and appropriate treatment, according to the approved protocol, and counsel the patient about the disease process and about the prescribed medication.

6. Assess the patient's understanding and provide patient education about follow-up examinations, the importance of sex partner examination, disease risk status, additional laboratory tests, and prevention methods.
7. Refer patients to other appropriate community resources when findings indicate problems beyond the scope of the STD clinic.
8. Refer patients for disease intervention according to established clinic guidelines.
9. Document all patient records, forms, and reports thoroughly and clearly, according to the requirements for each.
10. Use triage in counseling and referring any patients who cannot be examined and treated during clinic hours.
11. Participate in ongoing quality assurance and infection control practices.
12. Manage emergencies according to the standardized clinic protocol.
13. Assist in training other health care professionals and new clinic staff.
14. Participate in staff meetings and continuing education programs sponsored by the clinic or other designated agency.
15. Administer Mantoux skin tests and HIV counseling, if directed to do so.
16. Administration and documentation of oral and injectable medications according to clinic protocols.
17. Perform other duties as assigned.

Clinician Evaluation Form

Clinician:_____

Clinic:_____

Evaluator:_____ Date Evaluated:_____

Clinic Manager:_____ Date Reviewed:_____

Each clinician should be observed periodically to ensure the quality of patient services. This form can be used for recording such observations. After each standard, place a checkmark under the category that most closely fits the person's performance. This format can be used after observing one or several patients with the clinician.

STANDARD 1 = Needs improvement 2 = Satisfactory 3 = Excellent	1	2	3
INITIAL INTERACTION			
1. Cordially greets patient by name		/	/
2. Professionally introduces self and observer		/	/
3. Establishes rapport with patient		/	/
BASIC MEDICAL HISTORY			
Ascertains the following:			
1. Reason(s) for the visit		/	/
2. Description of symptoms			
- onset, duration, characteristics, frequency		/	/
- history of similar problems		/	/
- history of problems in a sex partner		/	/
3. History of STD including HIV (treatments, dates)		/	/
4. Medication history			
- recent antibiotic use (type, purpose, duration)		/	/
- other medications (type, purpose, date, duration)		/	/
- known drug allergy (drug, reaction, date)		/	/
5. History of blood tests for syphilis and HIV (date, place, result)		/	/
6. Review of general health:			
- recent pulmonary infections		/	/
- recent weight loss, night sweats, fatigue		/	/

	1	2	3
7. History of drug use and needle-sharing practices	/	/	
8. Review of recent sexual activity			
- time since last exposure	/	/	
- number and change of partner(s) in the last month	/	/	
- sexual preference(s)	/	/	
- exposure sites (oral, genital, anal)	/	/	
- sexual practices (STD risk assessment)	/	/	
- condom use	/	/	
9. Women - Reproductive history			
- date of last menses	/	/	
- unusual aspects of last menses (flow, duration, pain)	/	/	
- type of contraception (referral to family planning)	/	/	
PHYSICAL EXAM PREPARATIONS			
1. Gives appropriate instructions to patient	/	/	
2. Provides privacy for patient's disrobing/dressing	/	/	
3. Reinforces confidentiality	/	/	
4. Ensures patient is appropriately draped during exam	/	/	
5. Provides explanations before touching patient	/	/	
PHYSICAL EXAM			
1. Inspects face, trunk, forearms, palms, soles, for lesions, rashes, nodules, discoloration	/	/	
2. Inspects oropharynx for lesions and discoloration	/	/	
3. Palpates inguinal, femoral, cervical, supraclavicular, epitrochlear, and axillary lymph nodes	/	/	
4. Genital - Women:			
- inspects external genitalia (lice, nits, discharge, masses, lesions, tenderness)	/	/	
- inspects the vaginal mucosa (discharge amount, color, character, lesions)	/	/	

	1	2	3
- inspects the cervix (discharge amount, color, character, swab test)	/	/	
- notes presence of ectopy, induced endocervical bleeding, unusual findings	/	/	
- performs bimanual exam (cervical motion tenderness, uterine enlargement, adnexal tenderness, pelvic mass)	/	/	
- palpates Bartholin's and Skene's glands	/	/	
- inspects anus and perianal area	/	/	
Genital - Men:			
- inspects pubic hair (lice, nits)	/	/	
- inspects penis, meatus, foreskin (urethral discharge, color, amount, character, lesions)	/	/	
- palpates scrotum (testicular tenderness, mass)	/	/	
- inspects anus and perianal area	/	/	
5. Performs exam efficiently (time for uncomplicated exam: woman 30 minutes, men 20 minutes)	/	/	
LABORATORY SPECIMEN COLLECTION			
1. Collects all specimens appropriately			
- gram stain (gonorrhea, WBC)	/	/	
- gonorrhea culture(s) (endocervical/urethral, anal or oral if exposure site, DGI)	/	/	
- chlamydia diagnostic test (endocervical/ urethral)	/	/	
- STS (unless nonrective in last 30 days)	/	/	
- HIV antibody test (initial visit, genital ulcer, exposure)	/	/	
- Women - tests of vaginal discharge: Wet mount (trichomonas and clue), KOH mount (yeast), Gram stain (trichomonas, yeast, clue, pH)	/	/	
2. Collects additional tests based on history and physical findings	/	/	
- darkfield (chancre, rash, condylomata lata)	/	/	
- STS (unexplained lesion, sex partner to case)	/	/	

	1	2	3
- Hepatitis B serologic test or vaccination (gay or bisexual men, health care workers, injection drug users)	/	/	
- other STD tests	/	/	
- Mantoux skin test or referral (if HIV positive injection drug user)	/	/	
- Pap smear or referral (if not done in past year or if abnormal)	/	/	
- pregnancy test (suspected pregnancy)	/	/	
- STD tests during first and third trimester	/	/	
3. Correctly labels all specimens	/	/	
4. Collects and transports specimens correctly	/	/	
DIAGNOSIS AND TREATMENT			
1. Accurately determines and records the diagnosis	/	/	
2. Selects appropriate treatment	/	/	
MEDICAL CONSULTATION AND REFERRAL			
1. Provides appropriate referral to community resource	/	/	
2. Consults appropriately with physician (unsatisfactory exam, diagnosis uncertain, drug reaction, no standing order)	/	/	
3. Refers to appropriate specialist (hospitalization, prenatal care, contraception, urologic and prostatic disorder, drug reaction, surgery)	/	/	
4. Consults with DIS or makes referral when indicated	/	/	
COUNSELING/EDUCATION			
1. Clearly informs patient of diagnosis	/	/	
- name of disease, transmission, incubation, symptoms, if any	/	/	
- complications	/	/	
2. Stresses partner notification (sex partners seek STD medical evaluation)	/	/	
3. Gives risk-reduction messages	/	/	
- avoidance of sex with partners until examined	/	/	
- results and interpretation of tests	/	/	

	1	2	3
- safe sex (abstinence, monogamy, condoms)	/	/	
4. Counsels on prevention of future infections (stop having sex, seek care promptly if symptoms recur)	/	/	
5. Gives accurate medication instructions	/	/	
- name of medication and why it is used	/	/	
- how to take the medication and what to expect as treatment outcome	/	/	
- potential side effects	/	/	
6. Schedules follow-up exams	/	/	
- clinic procedure for follow-up exams	/	/	
- health consequences of not taking tests	/	/	
- recommends lifestyles/sexual activity changes until follow-up completed	/	/	
7. Provides patient handouts when appropriate (disease-specific, treatment-specific)	/	/	
8. Gives additional HIV risk-reduction messages			
- avoid injection drug use, sharing needles, unsterilized equipment	/	/	
- abstain from sex with persons suspected of HIV infection and other high risk individuals	/	/	
- seek HIV testing if past behavior puts one at risk for HIV	/	/	
- use latex condoms (multiple or new partners)	/	/	
- Men - Do not donate blood if sex with men since 1977	/	/	
- Women - Before pregnancy, seek HIV testing	/	/	
CLINICIAN'S ATTITUDE			
1. Invites patient to ask questions	/	/	
2. Answers patient questions appropriately	/	/	
3. Determines understanding of results/instructions	/	/	
4. Remains sensitive to patient's concerns	/	/	
5. Maintains a relaxed manner throughout the interaction	/	/	

	1	2	3
6. Maintains a nonjudgmental attitude	/	/	
EMERGENCY PRECAUTIONS			
1. Appropriate use of emergency protocol	/	/	
2. Emergency medications administered correctly	/	/	
FOLLOW-UP THERAPY			
1. Ascertains follow-up history	/	/	
- changes in symptoms	/	/	
- adverse reaction to drugs	/	/	
- compliance with instructions	/	/	
- sexual exposure since therapy	/	/	
- treatment status of sex partner(s)	/	/	
2. Collects appropriate laboratory tests (antibiotic sensitivity)	/	/	
DOCUMENTATION			
1. Legibly completes the medical record	/	/	
2. Records information collected from the patient	/	/	
3. Thoroughly completes the medical record	/	/	
4. Signs medical record	/	/	
BIOSAFETY PROCEDURES			
1. Follows biosafety and infection control protocol	/	/	

COMMENTS

Registration Clerk Evaluation Form

Clerk:_____

Clinician:_____

Evaluator:_____ Date Evaluated:_____

Clinic Manager:_____ Date Reviewed:_____

Each registration clerk should be observed periodically to ensure the quality of patient services. This form can be used for recording such observations. After each standard, place a checkmark under the category that most clearly fits the person's performance.

STANDARD
1 = Needs improvement
2 = Satisfactory
3 = Excellent

	1	2	3
1. Acknowledges the patient promptly when patient arrives at the registration area.			
2. Greets the patient cordially.			
3. Asks only relevant questions for registration.			
4. Handles patient information confidentially.			
5. Provides understandable oral instructions on policy and flow.			
6. Provides written handout describing clinic policy and flow.			
7. Answers patients' questions appropriately (person-to-person or via telephone).			
8. Retrieves medical records/information efficiently.			
9. Routinely checks the "expected-in" file.			
10. Completes necessary forms efficiently.			
11. Records all necessary information on daily logs.			
12. Consults with clinic manager or appropriate person when indicated.			

COMMENTS

Laboratorian Evaluation Form

Technician:_____

Clinic:_____

Evaluator:_____ Date Evaluated:_____

Clinic Manager:_____ Date Reviewed:_____

Each laboratorian should be observed periodically to ensure the quality of specimen testing. This form can be used for recording such observations. After each standard, place a checkmark under the category that most closely fits the person's performance. This format can be used after observing one or several testing procedures with the laboratorian.

STANDARD
1 = Needs improvement
2 = Satisfactory
3 = Excellent

	1	2	3
GRAM STAIN			
1. Uses approved gram-stain procedure.		/	/
2. Prepares gram-stain reagents appropriately.		/	/
3. Records and uses controls appropriately.		/	/
4. Examines specimens thoroughly.		/	/
5. Identifies gram-negative diplococci.		/	/
6. Ability to identify and enumerate WBCs.		/	/
7. Marks slides appropriately.		/	/
WET MOUNT			
1. Makes and stores saline appropriately.		/	/
2. Makes and stores KOH appropriately.		/	/
3. Lighting appropriate for specimen observation.		/	/
4. Examines specimens thoroughly.		/	/
5. Ability to identify		/	/
- clue cells, yeast, trichomonads.		/	/
6. Marks slides appropriately.		/	/
BRIGHTFIELD MICROSCOPY			
1. Maintains microscope adequately.		/	/
2. Seating and lighting appropriate.		/	/

	1	2	3
GONORRHEA CULTURE			
1. Stores media correctly.	/	/	
2. Media quality controlled.	/	/	
3. Inoculates plates correctly (Z and cross-streak).	/	/	
4. Sterilizes bacteriologic loop appropriately.	/	/	
5. Identifies plates and lab slips adequately.	/	/	
6. Places plates on CO_2 within 15 minutes.	/	/	
7. Places plates in 35-36°C within 1 hour	/	/	
8. Presumptive identification	/	/	
- cultures read at 24, 48, and 72 hours	/	/	
- colonial morphology correctly identified	/	/	
- oxidase reagent prepared properly	/	/	
- gram stain appropriately prepared	/	/	
9. Uses culture confirmation appropriately	/	/	
SEROLOGIC TESTS FOR SYPHILIS			
1. Uses nontreponemal antibody card test appropriately	/	/	
2. Checks needle delivery	/	/	
3. Checks rotator speed (100 rpm)	/	/	
4. Uses card test controls appropriately	/	/	
5. Room temperature appropriate for test	/	/	
6. Uses high-intensity lamp	/	/	
7. Quantifies reactive specimens to end point	/	/	
8. Ability to determine reactivity	/	/	
9. Uses reference lab appropriately	/	/	
10. Blood centrifuged in Biosafety Level II device	/	/	
11. Identifies tubes and lab slips appropriately	/	/	
DARKFIELD MICROSOPY			
1. Maintains darkfield scope(s) properly	/	/	
2. Uses appropriate procedures to locate specimen	/	/	
3. Examines specimens thoroughly	/	/	
4. Room lighting appropriate	/	/	
5. Ability to identify and differentiate treponemes	/	/	
6. Identifies slides properly	/	/	

	1	2	3
SAFETY			
1. Uses universal precautions routinely	/	/	
2. Injury surveillance system in place	/	/	
3. Follows general and special microbiologic practices	/	/	
4. Stores supplies safely	/	/	
5. Maintains quality control records daily	/	/	
6. Keeps work area tidy	/	/	
DOCUMENTATION			
1. Processes specimens quickly	/	/	
2. Marks lab slips appropriately	/	/	
3. Returns reports promptly to clinicians	/	/	
4. Records results in log correctly	/	/	
5. Notifies clinician if specimen is inadequate	/	/	

COMMENTS

Management of Acute Drug Reactions

Anaphylaxis

Anaphylactic reactions are reported most frequently following therapy with antibiotics, particularly with the penicillins and the cephalosporins. Profound shock and severe respiratory distress are the hallmarks of severe anaphylactic reactions. The clinical presentation of an anaphylactic reaction depends on the mode of entry of the antigen or foreign substance, and amount absorbed, the rare of absorption, the rate of absorption, and the patient's degree of hypersensitivity. For example, ingestion of an antigenic substance may produce gastrointestinal symptoms such as nausea,vomiting, abdominal cramping, and diarrhea, which precede more severe symptoms; in contrast, following an antigenic injection, severe life-threatening shock and respiratory distress may occur without the preceding symptoms. The signs and symptoms associated with anaphylactic reaction may cover a wide range of severity.

These reactions represent true medical emergencies; therefore, prompt recognition is critical. An immediate response and appropriate management increase the likelihood of the best possible outcome.

At the first suspicion of a drug reaction, a clinician should immediately use a predetermined system to notify clinic staff of the emergency situation and its location. The clinician should remain with the patient and initiate basic supportive measures. Designated staff should respond immediately and assist in the emergency. Each staff member should have a designated task with one staff member designated to call the ambulance once the need is established. A preselected clinician should be in charge and should make all therapeutic decisions, according to approved protocols.

The maintenance of an airway and adequate ventilation are first priorities in the management of patients with anaphylactic reactions. Epinephrine is the drug of choice for treating the acute manifestations of anaphylaxis such as bronchoconstriction and hypotension.

Management

1. Mild Anaphylactic Reaction or Urticaria Alone

   a. Epinephrine, 1:1,000, 0.3-0.5 ml, SQ or IM
   b. Diphenhydramine, 25-50 mg, IM
   c. If the response is adequate (decreasing pruritus and lessening of rash), prescribe for adults and antihistamine (e.g., diphenhydramine, 25-50 mg; chlorpheniramine, 4 mg; or promethazine, 12.5 mg) to be taken 3-4 times a day as needed

d. If the response is inadequate or if other symptoms occur, continue supportive and therapeutic measures and transport the patient to an emergency facility

2. Less Severe Anaphylactic Reaction (without hypotension or loss of consciousness)

a. Epinephrine 1:1,000, 0.3-0.5 ml, SQ or IM; dose may be repeated twice, at 5-10 minute intervals, PRN
b. Diphenhydramine, 25-50 mg, IM; this agent does not play a significant role in the management of life-threatening emergencies but may be useful after the patient is stabilized

3. Severe Anaphylactic Reactions

a. Place the patient in a supine position, with the legs elevated (Trendelenburg position)
b. Maintain an adequate airway and ventilation. An oral airway may be of benefit; if not, endotracheal intubation will be necessary.
c. Assess the vital signs and patient's neurologic status
d. Administer oxygen and other pharmacologic agents as per emergency protocol
e. Periodically reassess the patient's vital signs
f. Start an intravenous line and give epinephrine 1:1,000, 0.5-1.0 ml,, in 10 cc of normal saline IV. Repeat every 5-15 minutes as necessary. If no venous access, epinephrine may be given through the endotracheal tube.
g. For severe bronchospasm without shock, give aminophylline, 500 mg IV, over 10-20 minutes
h. Transport the patient to an emergency facility
i. all emergency procedures and drugs provided must be recorded on an appropriate form that will accompany the patient to the emergency facility. A copy should be kept in the patient's medical chart at the STD clinic.

Procaine Reactions

Procaine reactions are not allergic reactions. Two types of reactions following procaine injection have been described. The first type involves extreme anxiety. Some patients experience disorientation, hallucinations, and agitation. Such reactions are generally the result of direct procaine toxicity and usually resolve within 15-30 minutes. The second type of reaction is similar, but hyperventilation, hypertension, tachycardia, and vomiting may occur. Hypotension may occur in severe cases. The reaction is usually due to inadvertent intravenous injection of procaine.

Management

1. Establish that the patient is not hypotensive, not in respiratory distress, and does not have allergic manifestations.

2. Place the patient in a supine position. Use physical restraint if necessary.
3. Provide calm and continuous verbal reassurance and any supportive care necessary.

Characteristics of Adverse Reactions to Antimicrobials Commonly Used in STD Clinics

Acyclovir

Contraindications

1. Patient with known hypersensitivity to this drug

Adverse reactions

1. In clinical trials, 3% of participants experienced nausea or vomiting.
2. In clinical trials of continuous administration (up to 6 months), the most frequent adverse reactions were headache, nausea, diarrhea, and vomiting.

Note: Caution should be exercised in acyclovir administration during pregnancy and to nursing mothers.

Ceftriaxone (Rocephin)

Caution should be exercised when using cephalosporins; the patient should be asked about allergy to penicillin. In those patients with known penicillin allergy, ceftriaxone should be given with caution in the health department setting.

Contraindications

1. Patients with known allergy to the cephalosporin class of drugs.

Adverse reactions

1. Ceftriaxone is generally well tolerated. The most common adverse reactions are hematologic disorders such as eosinophilia, thrombocytosis, and leukopenia. Diarrhea following administration has also been reported.

Erythromycin

Contraindications

1. Patients with known hypersensitivity to this antibiotic

Adverse reactions

1. Gastrointestinal cramping and discomfort are dose related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses.
2. Dermatologic allergic reactions such as urticaria and other skin rashes have occurred.

Metronidazole (Flagyl)

Contraindications

1. History of allergy to metronidazole or other nitroimidazole derivatives
2. In the first trimester of pregnancy

Adverse reactions

1. Convulsive seizures and peripheral neuropathy have been reported; appearance of abnormal neurological signs demands prompt discontinuation of metronidazole therapy.
2. Some patients taking metronidazole may experience a disulfiram reaction after the ingestion of alcohol. Consumption of alcohol should be avoided during therapy and for one day after completion of therapy. Patients should be warned that drinking alcohol during metronidazole therapy may result in tachycardia, palpitations, flushing, and nausea. Also, metronidazole may potentiate the anticoagulant effects of warfarin.

3. Overgrowth of Candida albicans occurs during effective therapy; glossitis and stomatitis have occurred.

Penicillin (including ampicillin and amoxicillin)

Contraindications

1. A previous hypersensitivity reaction to any penicillin
2. When using penicillin G benzathine, or penicillin G procaine suspension, **do not** inject into or near an artery or nerve.

Adverse reactions

1. Hypersensitivity reactions including anaphylaxis, maculopapular rash, exfoliative dermatitis, laryngeal edema, and fever
2. Inadvertent intravascular administration, including inadvertent direct intraarterial injection, or injection immediately adjacent to arteries, of Bicillin and other penicillin preparations has resulted in severe neurovascular damage, including transverse myelitis with permanent paralysis, gangrene requiring amputation of digits and more proximal portions of extremities, and necrosis and sloughing at and surrounding the injection site.

Immediate reaction

Time: Within minutes after administration

Characteristics: Diffuse (giant) urticaria, laryngeal edema, wheezing, rhinitis, hypoxia, hypotension, tachycardia, nausea, vomiting, abdominal pain, diarrhea, rigors, vascular collapse

Accelerated reaction

Time: 30 minutes to 48 hours after administration

Characteristics: Urticaria, laryngeal edema (infrequently)

Delayed reaction

Time: Usually more than 3 days after administration

Characteristics: Erythema, urticaria, exfoliative dermatitis, Stevens-Johnson syndrome, contact dermatitis, bullous eruptions, serum sickness, hematologic reactions, lupus-like syndrome, vasculitis, drug fever, hepatitis, nephropathy

Note: For discussion of Procaine reaction, to "Management of Acute Drug Reactions"

Pentamidine

Pentamidine is known to have activity against Pneumocystis carinii. In vitro studies indicate that the drug interferes with protozoal nuclear metabolism by inhibition of DNA, RNA, phospholipid and protein synthesis. The inhalation solution of pentamidine is indicated for the prevention of Pneumoncystis carinii pneumonia (PCP) in high-risk, HIV-infected patients defined by one or both of the following criteria:

1. a history of one or more episodes of PCP
2. a peripheral CD_4+ lymphocyte count less than or equal to 200/mm^3

Contraindications

1. history of an anaphylactic reaction to inhaled or parenteral pentamidine isethionate

Adverse reactions

1. Cough and bronchospasm (reported by 38% and 15%, respectively, of patients receiving 300 mg every four weeks)
2. Other adverse reactions may include fatigue, metallic taste, shortness of breath, decreased appetite, dizziness, and rash.

Quinolones (Ciprofloxacin; Norfloxacin)

Contraindications

1. history of hypersensitivity to the fluoroquinolone class of drugs
2. should not be used in children or pregnant women

Adverse reactions

1. Gastrointestinal symptoms are the most frequently reported and include: nausea, vomiting, diarrhea, and abdominal discomfort.
2. Dermatologic manifestations including urticaria, pruritus, flushing, and edema of the face, neck, lips, and hands have been reported.
3. Central nervous system stimulation leading to tremor, restlessness, and light-headedness; administer with caution in patients with known convulsive disorders.

Note: Caution patient against the use of antacids during ciprofloxacin therapy. Aluminum and magnesium contained in antacids will bind to ciprofloxacin decreasing its bioavailability, with resulting loss of therapeutic value.

Spectinomycin (Trobicin)

Contraindications

1. Known spectinomycin allergy
2. Safety in children has not been established.
3. Safety in pregnancy has not been established.

Adverse reactions

1. Soreness at site of injection, urticaria, dizziness, nausea, chills, fever and insomnia have been reported after single dose in clinical trials.
2. No confirmed cases of anaphylaxis

Tetracycline (including doxycycline)

Contraindications

1. Patients with known allergy to the tetracycline class of drugs
2. Use during pregnancy can cause discoloration of the teeth in newborns even from repeated short-term use; enamel hypoplasia has also been reported.
3. In patients with renal impairment, excessive systemic accumulation will lead to liver toxicity; dosage should be reduced and serum level determinations should be performed; with renal impairment, administration can lead to increased levels of blood urea nitrogen (BUN) with resulting azotemia, hyperphosphatemia, and acidosis.
4. The use of drugs of the tetracycline class during tooth development (last half of pregnancy, infancy, and childhood to the age of 8 years) may cause permanent discoloration of the teeth.

Adverse reactions

1. Photosensitivity, manifested by a sunburn reaction; therapy should be discontinued at the first sign of erythema.
2. Hypersensitivity, in the form of urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, and exacerbation of lupus erythematosus have been reported.
3. Gastrointestinal symptoms (i.e., anorexia, vomiting, nausea) have been reported.
4. Maculopapular and erythematous skin rashes have been reported.
5. Concurrent use of tetracycline may render oral contraceptives less effective. Breakthrough bleeding has been reported.

Note: Antacids containing calcium, aluminum, or magnesium impair absorption and should not be given to patients taking oral tetracycline. Dairy products, which are high in calcium, should also be avoided. Oral forms of tetracycline should be given 1 hour before or 2 hours after meals.

Zidovudine (formerly azidothymidine or AZT)

During zidovudine therapy, concomitant use of the following drugs will increase the risk of zidovudine toxicity: dapsone, flucytocine, indomethacin, pentamidine, probenecid, and vincristine.

Contraindications

1. Known allergy to zidovudine or to any of its chemical components

Adverse reactions

1. Possible granulocytopenia and anemia
2. Severe headache, nausea, insomnia, and myalgia have been reported
3. Because of the potential for serious adverse reactions from zidovudine in nursing infants, mothers should be instructed to discontinue nursing if they are receiving zidovudine.

Laboratory Biosafety Level Criteria

Biosafety levels consist of combinations of laboratory practices and techniques, safety equipment, and laboratory facilities appropriate for the operations performed, the hazard posed by the infectious agents, and for the laboratory functions or activities. STD stat laboratories fall under Biosafety Level 2: moderate risk agents associated with human disease, work on open benches, low potential for aerosol production with certain operations confined to biological safety cabinets.[1]

Standard Microbiologic Practice

1. Access to laboratory should be appropriately limited.
2. Work surfaces should be decontaminated daily.
3. Work surfaces should be decontaminated immediately after spill.
4. All infectious waste should be decontaminated before disposal.
5. Mouth pipetting should be avoided.
6. Eating, drinking, food storage, and smoking should be avoided.
7. Thorough handwashing should be performed after handling infectious materials and before leaving the laboratory.
8. Procedures to minimize the creation of aerosols should be followed.

Special Microbiologic Practice

1. Contaminated materials should be placed in durable leak-proof container and decontaminated at another site.
2. Universal biohazard symbol should be posted on the laboratory door, along with identification of infectious agents and the name of the laboratory director.
3. Laboratory coats, gowns, smocks, or uniforms should be worn only in lab; lab coats should be removed and left in laboratory upon exiting.
4. Universal precautions for blood and body fluids should be instituted.
5. Needles and syringes should be promptly placed in puncture-proof containers for decontamination.
6. Use of glass should be eliminated whenever possible.

Design of Laboratory

1. Design should facilitate easy cleaning.
2. Bench tops should be impervious to water and resistant to acids, alkalis, organic solvents, and moderate heat.
3. Sink for handwashing should be near the door.
4. Autoclave should be available for decontaminating infectious waste.

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[1] U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and National Institutes of Health. Biosafety in Microbiological and Biomedical Laboratories. (2nd edition; U.S. Government Printing Office, Washington: 1988)

Biological Safety Equipment

1. Safety cabinets and pipetting devices should be routinely checked to ensure proper operation.
2. Items for personal protection such as gloves, coats, masks and face shields should be present.

Surveillance Definitions

The following descriptions and definitions apply to reporting of sexually transmitted diseases and are not for diagnostic purposes. These surveillance definitions were approved in 1990 by the association of state and territorial epidemiologists to promote consistency in reporting stds among the states. However, the laws on reporting regulations in each must be followed. Since reporting definitions are designed to be concise and do not include all options available to a clinician in determining a diagnosis, the terns suggestive, presumptive, and confirmed are used for diagnostic criteria. The terms probable and confirmed are used in surveillance and reporting.

Despite this difference in terminology, we suggest that clinic and program management information systems be organized so that appropriate data can be retrieved both for surveillance audits and for clinical audits. Computer based surveillance systems could be programmed to identify multiple fields on the clinic record such as symptoms linked to laboratory findings.

Disease	Organism	Probable	Confirmed	Comments
Chancroid	Hemophilus ducreyi	A clinically compatible case with one or more painful genital ulcers and both a) no evidence of Treponema pallidum infection by darkfield examination of ulcer exudate or by a serologic test for syphilis performed at least 7 days after onset o ulcers and b) the clinical presentation of the ulcer(s) is not typical of disease caused by herpes simplex virus (HSV) or the HSV culture is negative.	A case that is laboratory confirmed.	
Chlamydia	Chlamydia Trachomatis		A case that is laboratory confirmed by isolation of chlamydia trachomatis by culture or by antigen detection methods.	
Genital warts	Human papillomavirus	A clinically compatible case without histopathological diagnosis and without microscopic or serologic evidence that the growth is due to secondary syphilis		

Disease	Organism	Probable	Confirmed	Comments
Gonorrhea	Neisseria gonorrhea	Demonstration of gram-negative intracellular diplococci in an endocervical smear obtained from a woman or a written (morbidity) report of gonorrhea submitted by a physician	A case that is laboratory confirmed	
Granuloma inguinale	Calymmato-bacterium granulomatis	A clinically compatible case (in which primary and secondary syphilis have been ruled out by serology and darkfield microscopy, when available) with either a diagnosis of genital herpes based on clinical presentation (without laboratory confirmation) or a history of one or more previous episodes of similar genital lesions.	A clinically compatible case that is laboratory confirmed	
Genital herpes	Herpes simplex virus (HSV)		A clinically compatible case that is laboratory confirmed	Herpes should be reported only once per patient. The first diagnosis for a patient with no previous diagnosis should be reported
Lymphogran-uloma venereum	Chlamydia trachomatis	A clinically compatible case with one r more tender fluctuant inguinal lymph nodes or characteristics proctogenital lesions with supportive laboratory findings of a single C. trachomatis complement fixation(CF) titer of >64	A case that is laboratory confirmed	

Disease	Organism	Probable	Confirmed	Comments
Nongonococcal urethritis (NGU)	C. trachomatis Ureplasma urealyticum Mycoplasma hominis		A clinically compatible case among males in whom gonorrhea is not found, either by culture or gram stain	Nongonococcal urethritis is a clinical diagnosis of exclusion. The syndrome may result from infection with several agents (see chlamydia trachomatis infection). A clinically compatible case excluding gonorrhea and chlamydia should be classified as NGU. An illness among men that meets the case definition of NGU and C. trachomatis infection should be classified as Chlamydia.
Mucopurulent cervicitis (MPC)	C. trachomatis (and others)		A clinically compatible case among females for whom gonorrhea and trichomonas infection are not found	Mucopurulent cervicitis is a diagnosis of exclusion. The syndrome may result from infection with several agents (see Chlamydia trachomatis infection). If gonorrhea, trichomoniasis, and chlamydia are excluded, a clinically compatible case should be classified as MPC. An illness among women that meets the case definition of MPC and Chlamydia trachomatis infection should be classified as chlamydia

Disease	Organism	Probable	Confirmed	Comments
Pelvic Inflammatory Disease (PID)	C. trachomatis N. gonorrhea		A confirmed case must meet the clinical case definition: a clinical syndrome resulting from the ascending spread of microorganisms from the vagina and endocervix to the endometrium, fallopian tubes, and/or contiguous structures. All of the following criteria must be present: 1. abdominal direct tenderness 2. tenderness with motion of the cervix 3. adnexal tenderness In addition to all of the above criteria, at least one of the following findings must also be present: 1. meets the surveillance case definition for Chlamydia trachomatis infection or gonorrhea 2. temperature of >38°c 3. leukocytosis > 10,000 WBC/mm^3 4. purulent material in the cavity obtained by caldocentesis or laparoscopy 5. pelvic abscess or inflammatory complex on bimanual examination or by sonography 6. patient is a sexual contact of a person known to have gonorrhea, chlamydia, or nongonococcal urethritis	For reporting purposes, a clinician's report of pelvic inflammatory disease should be counted as a case

Disease	Organism	Probable	Confirmed	Comments
Syphilis	Treponema pallidum	A clinically compatible case with one or more ulcers (chancres) consistent with primary syphilis and a reactive serologic test	A clinically compatible case that it laboratory confirmed	laboratory criteria for diagnosis is demonstration of Treponema pallidum in clinical specimens by darkfield, fluorescent antibody, or equivalent microscopic methods
Secondary syphilis	T. pallidum	A clinically compatible case with a reactive nontreponemal (VDRL, RPR) test titer of ≥ 1:4	A clinically compatible case that is laboratory confirmed	
Early latent syphilis	T. pallidum	Person with latent syphilis who has evidence (see following) of having acquired the infection within the previous 12 months: 1. a nonreactive serologic test for syphilis or a nontreponemal titer that has dropped fourfold within the past 12 months 2. a history of symptoms consistent with primary or secondary syphilis without a history of subsequent treatment in the past 12 months 3. a history of sexual exposure to a partner with confirmed or presumptive early latent syphilis, and no history of treatment in the past 12 months 4. reactive nontreponemal and treponemal tests from an individual whose only possible exposure occurred within the preceding 12 months		

Disease	Organism	Probable	Confirmed	Comments
Latent syphilis	T. pallidum	No clinical signs or symptoms or syphilis and the presence of one of the following: 1. no past diagnosis of syphilis and a reactive treponemal (FTA-ABS, OR MHA-TP) test 2. a past history of syphilis therapy and a current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer		
Late latent syphilis	T. pallidum	Latent syphilis of a patient who shows no evidence of having acquired the disease within the past 12 months (see: early latent syphilis) and whose age and titer do not meet the criteria specified for unknown latent syphilis		
Unknown latent syphilis	T. pallidum	Latent syphilis that does not meet the criteria for early latent syphilis, ant the patient is 13-35 years of age with a nontreponemal test serologic titer of ≥ 32		
Neurosyphilis	T. pallidum	Syphilis of any stage, a nonreactive VDRL-CSF, and both of the following: 1. Elevated CSF protein or leukocyte count in the absence of other known causes of these abnormalities 2. clinical symptoms of signs consistent with neurosyphilis without other known causes for these clinical abnormalities	Syphilis of any stage that meets the laboratory criteria for neurosyphilis	

Disease	Organism	Probable	Confirmed	Comments
Congenital syphilis	T. pallidum	The infection of an infant whose mother had untreated or inadequately treated* syphilis at delivery, regardless of signs in the infant; or the infection of an infant or child who has a reactive treponemal test for syphilis and any one of the following: 1. any evidence of congenital syphilis on physical examination 2. any evidence of congenital syphilis on long bone x-ray 3. a reactive VDRL-CSF 4. an elevated CSF cell count or protein (without other cause) 5. a reactive test for fluorescent treponemal antibody absorbed-19S-IgM antibody	A case (among infants) that is laboratory confirmed	*Inadequate treatment consists of any nonpenicillin therapy or penicillin given < 30 days before delivery Congenital and acquired syphilis may be difficult to distinguish when a child is seropositive after infancy. Signs of congenital syphilis may not be obvious, and stigmata may not yet have developed. Abnormal values for VDRL-CSF cell count, and protein, as well as IGM antibodies, may be found in either congenital or acquired syphilis. Findings on long bone x-rays changes in the metaphysis and the epiphysis are considered classic for congenitally acquired disease. The possibility of sexual abuse should be considered. For reporting purpose, congenital syphilis includes cases of congenitally acquired syphilis among infants and children, as well as syphilitic stillbirths.
Syphilitic stillbirth	T. pallidum			For reporting purposes, syphilitic stillbirths should be reported as cases of congenital syphilis

1

MEDICAL INDICATORS OF ABUSE/NEGLECT

SEXUAL ABUSE

SUSPECTED SEXUAL ABUSE

FEMALE/VAGINAL FINDIGS

- Lacerated hymen
- Thickened or scarred hymen
- Synechiae from labia to hymen
- Synechiae from hymen to vaginal wall
- Enlarged hymen diameter
- Lacerated,friable, or scarred fourchette
- Injury to the perinuem
- Injected lesions
- Vaginitis
- Vulvitis
- Tears or infected lesions of the mouth or anus
- Presence of semen
- Discharge
- Vulvar hematoma
- Pregnancy
- Presence of sexually transmitted disease
- Recurrent urinary tract infections
- Laceration, bruise, or bleeding from External genitalia, vaginal or anal region
- Torn, stained, or bloody underclothes
- Pain or itching in genital area
- Dysuria
- Hematuria
- Necrosis
- Genita erythema

MALE FINDINGS

- Bruised or swollen scrotum or penis
- Trauma to scrotum/testicles
- Abnormal markings on the penis
- Tears or infected lesions of the mouth or anus
- Presence of sexually transmitted disease
- Torn, stained, or bloody underclothes
- Pain or itching in genital area
- Anal findings(see below)

ANAL FINDINGS

- Anal lacerations
- Ruptured anal sphincter
- Tears/fissures
- Edema
- Scarring(superficial and deep)
- Hyperpigmentation
- Decreased tone
- Altered anal markings
- Tags
- Reflex dilitation
- Venus congestion

CHRONIC FINDINGS/OLD INJURY

- Attenuated hymen
- Decreased vascularity or neovascularity
- Decreased elasticity
- Scars
- Hymenal transectims
- V & U shaped deformities
- Rolled/thickened hymenal margins
- funneling

1

MEDICAL INDICATORS OF ABUSE/NEGLECT

- bald spots on infant (generally back of head from surface contact)
- deprivational dwarfism
  - small stature
  - distended abdomen
  - below normal weight
  - retarded skeletal maturation
- severe cradle cap
- bruises on forehead from head banging

Differential Diagnosis

- contributing factors, such as poverty, inadequate parenting knowledge, lack of transportation
- constitutional short stature
- folk medicine practices
- religious practices, beliefs
- severe acute malnutrition
  - extreme thinness
  - near normal bone growth
- organic failure to thrive
- genetic causes, such as cystic fibrosis, degenerative brain disease, chromosomal abnormalities, metabolic or endocrine disease or congenital anomalies (syndromes)
  - intrauterine or postpartum infection
  - birth trauma with subsequent brain trauma
- IUGR
- lead poisoning
- previously undiagnosed deafness, blindness, mental retardation, seizure disorder, or cerebral palsy

1

BEHAVIORAL INDICATORS OF PHYSICAL NEGLECT

A combination or **pattern** of indicators should alert you to the possibility of physical neglect.

CHILD

- Chronic uncleanliness, or poor hygiene, including lice, scabies, severe or untreated diaper rash, bedsores, body odor
- Chronic hunger, begging, stealing food
- Unattended physical problems or medical needs
- Given inappropriate food, drink, or medication
- Repeatedly ingests harmful substances
- Developmental delay
- Clothing inappropriate to the weather, basic articles of clothing missing
- Assumes adult responsibilities
- States no caretaker at home

PARENT

- Consistent failure to keep appointments
- Failure to follow through on obtaining necessary medical or dental care
- Evidence of apathy or hopelessness
- Overwhelmed by poverty or an environment they can't control
- History of neglect as a child
- Substance abuse

2

DISTINGUISHING ABUSE FROM ACCIDENT

One of the most crucial indications that a child's injuries are the result of abuse is the poor fit between the history of an injury and the actual physical evidence.

When observing an injury you suspect might be the result of abuse, consider:

- **Location of the injury.** Certain locations on the body such as the knees, elbows, shins, or forehead are more likely to sustain non-abusive injury than nonprotuberant areas such as the back, thighs, genital area, buttocks, back of the legs, or face.

- **Number and frequency of injuries.** The greater the number of injuries, the greater the cause for concern. Unless the child is involved in a serious accident, he/she is not likely to sustain a number of different injuries. Multiple injuries in different stages of healing are suspicious.

- **Size and shape of the injury.** Non-intentional injuries usually have no defined shape. Intentional injuries, especially those inflicted with a familiar object such as stick, belt, hair brush, or looped cord bear a resemblance to the object used.

- **Description of how the injury occurred.** If an injury is non-intentional, there should be a reasonable explanation of how it happened that is consistent with the presentation of the injury. Injuries that are inconsistent with the explanation given are cause for suspicion.

- **Consistency of injury with the child's developmental capability.** When assessing an injury, consider whether the child is developmentally capable of causing his or her own injuries. Also consider the child's size and whether he/she is able to generate sufficient force to create the injury.

Remember that accidents do happen. Parents are not perfect. Injuries do occur that might have been avoided. However, abuse should be considered when injuries recur and/or the explanation is **inconsistent** with the injury or the child's developmental abilities.

3

HOW TO REPORT?

When you suspect that a child is being abused or neglected, **you should make a report, within 72 hours, to the local department of social services in your community.** Local social services departments are open during daytime business hours and their telephone numbers are listed on page 51 of this booklet.

Reports can also be made to the Child Abuse and Neglect Hotline (1-800-552-7096), seven days a week, 24 hours a day.

When making a report, the following information should be provided, **if known**:

- the name, address, and telephone number of the child and parents or other person(s) responsible for the child's care;
- the child's birthdate or age, sex, and race;
- a description of the nature of the injuries or condition;
- history of prior injuries or maltreatment of the child or siblings;
- reasons for suspecting abuse or neglect;
- medical services needed;
- the names and ages of other persons who live with the child and their relationship to the child;
- the name, address, and telephone number of the suspected abuser and his/her relationship to the child;
- any other pertinent information; and
- your name, address, and phone number.*

* Medical professionals are encouraged to inform the parents of the report to child protective services, however, reports can also be made anonymously and/or you can request that your name be held in confidence.

5

INTERVIEWING THE CHILD

If possible, the child should be interviewed in private and separate from the parent or caretaker.

Parental permission to interview the child or siblings, outside the presence of the caretaker, is not necessary pursuant to Section 63.1-248.10 of the Code of Virginia.

When interviewing the child:

- Attempt to gain pertinent information from others, prior to the interview, including the specifics of the abuse and a social history;
- Make sure the child is comfortable. Adjust your manner accordingly to convey reassurance and caring;
- Do not be rushed, allow yourself and the child plenty of time;
- Sit near the child, not across a desk or table, and at the child's eye level;
- Explain the purpose of the interview in language appropriate to the child's developmental level;
- Use the child's own words;
- Ask the child to explain words or terms that are unclear;
- Acknowledge that the situation must have been difficult for the child and emphasize that the child was not at fault;
- Ask the child if he/she has any questions and answer them; and
- Let the child know what is going to happen; **be careful not to make promises that you can't keep or are beyond your control.**

Do Not:

- Suggest answers or press the child for answers that he/she is unwilling to give.

5

PHYSICAL EXAMINATION

A thorough physical examination should be performed on every child suspected of being physically abused or neglected. The goals of the examination should be to:

- identify trauma or conditions requiring medical attention;
- document evidence of abuse or neglect; and
- provide assurance to the child and/or parents concerning the course of treatment.

In situations of suspected child sexual abuse where the last sexual contact occurred **within 72 hours of examination**, physical evidence should be collected utilizing the Physical Evidence Recovery Kit (PERK) available at most hospital emergency rooms or from local law enforcement.

PHOTOGRAPHS AND X-RAYS

Section 63.1-248.13 of the Code of Virginia allows photographs and x-rays to be taken of the child, as part of the medical evaluation, without the consent of the parent or guardian.

5

RELEASE OF MEDICAL RECORDS TO CHILD PROTECTIVE SERVICES

During the course of a child abuse or neglect investigation, the child protective services (CPS) worker may request the release of medical records.

Section 63.1-248.3 of the Code of Virginia authorizes medical professionals to release any records or reports which document the basis for the report of suspected abuse or neglect. The medical professional is responsible for determining which records are necessary for release to CPS.

Medical reports that are contained in CPS records may not be released without authorization from the medical practicioner, except to the Commonwealth's attorney, a CPS hearings officer, or a court determining an issue arising from a child abuse or neglect complaint.

PROTECTIVE CUSTODY

When there is immediate danger to a child's well-being, Section 63.1-248.9 of the Code of Virginia permits law enforcement, child protective services (CPS), or physicians to take a child into protective custody for up to 72 hours without parental consent.

The circumstances of the child must be such that:

- continuing the child in the care of the parent or guardian presents an imminent danger to the child's life or health to the extent that severe or irremediable injury would be likely to result, before a court hearing can be held;
- a court order is not immediately obtainable;
- the court has set up procedures for placing such children;
- the parents or guardian are immediately notified that the child is in custody;
- a report is made to CPS; and
- the juvenile and domestic relations court is notified.

A civil court hearing will follow.

The Virginia Department of Health is committed to providing the latest approved medications for HIV positive persons who qualify.

We believe in working with you to maintain state-of-the-art-care.

For more information about ADAP or the phone number of your local health department, please call:

Virginia HIV/STD/Viral Hepatitis Hotline
1-800-533-4148
(Voice/TDD)

The Virginia Department of Health's ADAP is supported by State and Ryan White CARE Act funds.

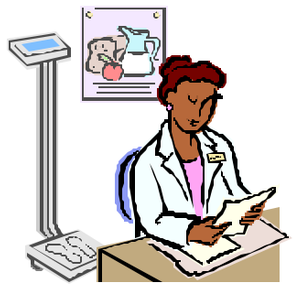
Virginia AIDS Drug Assistance Program (ADAP)

Information for Providers

Revised August 2002

Eligibility

1. A health care provider must have diagnosed the client with HIV infection or AIDS. A note on a prescription is acceptable. All client eligibility determination for ADAP is conducted at local health departments.



The prescription must include: CD4 count, HIV viral load, and medication. This information is needed every six months for anti-HIV medications, and once a year for opportunistic infection (OI) protection medication. Lab values should include the date the lab work was completed.

Anti-HIV medications will be provided if: The CD4 count is or was less than 500; the CD4 count is over 500 with a detectable viral load; or the client is pregnant (in which case, we will provide AZT until the patient qualifies for Medicaid). OI protection medications will be provided for:

PCP Prophylaxis -if client has or had a CD4 count lower than 250 or active thrush (for trimethoprim, dapsone, TMP/SMX, AP or atovaquone); **MAC Prophylaxis** -if the client has or had a CD4 count lower than 100 for rifabutin or azithromycin); or **The client currently has an OI.** The client cannot have health insurance for the prescribed medication.

2. The client must be determined ineligible for Medicaid. The health department may use a short Medicaid screening form to determine if the client should be referred to Social Services to apply for Medicaid. If client is referred, a letter verifying application from the Social Services Case Manager must be provided within 90 days of entry into ADAP. The local health department will provide your client with medications through ADAP until Medicaid is approved. If a client loses Medicaid coverage, medications will again be provided through ADAP.

   Patients who are eligible for or have Medicaid may not utilize ADAP. **Persons incarcerated in jails or prisons may not utilize ADAP.**

3. Yearly FAMILY income cannot be more than 300% of poverty level. For Northern Virginia, this number is slightly higher. The local health department can help the client determine this and will let them know if they qualify. Instruct new clients to bring proof of income like a pay stub or recent income tax form (1040).

4. **Rifabutin (Mycobutin): For treatment of MAI, only for those clients currently on it and those unable to tolerate Zithromax. Clients on Mycobutin should be switched to Zithromax if possible. Can be prescribed for treatment of TB infection.**

5. Itraconazole is available in a liquid suspension of 100mg.

6. Hydoxyurea must be given in combination with a nucleoside reverse transcriptase analogue (NRTI).

7. Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs): nevirapine (Viramune) and delavirdine (Rescriptor) must be ordered with a nucleoside analogue. Efavirenz (Sustiva) must be ordered with at least one other antiretroviral agent.

8. **Active therapy for any OI will be covered as a stop gap as long as funding is available. We strongly encourage providers to enroll these patients in Medicaid programs.**

Available Medications

Nucleoside RTIs

Combivir	(zidovudine + lamivudine)
Epivir	lamivudine (3TC)
Hivid	zalcitabine (ddC)
Retrovir	zidovudine (AZT, ZDV)
Trizivir	(abacavir, lamivudine + idovudine)
Videx	didanosine (ddi)
Zerit	stavudine (D4T)
Ziagen	abacavir

Nucleotide RTIs

Viread	tenofovir

Non-nucleoside RTIs

Rescriptor	delavirdine (DVD)
Sustiva	efavirenz
Viramune	nevirapine (NVP)

Protease Inhibitors

Agenerase	amprenavir
Crixivan	indinavir
Fortovase	saquinavir soft-gels
Invirase*	saquinavir (SQV)
Kaletra	lopinavir + ritonavir
Norvir	ritonavir (RTV)
Viracept	nelfinavir (NFV)

OI Protection/Treatment

Aerosolized pentamidine	(AP)
Amikin	amikacin
Bactrim/Septra	TMP/SMX
Biaxin	clarithromycin
Capastat	capreomycin
Cidofovir	vistide
Cytovene (IV)	ganiciclovir (DHPG)
Dapsone	
Diflucan (po)	fluconazole (po)
Foscovir (IV)	foscarnet
INH	isoniazid
Levoquin	levofloxacin
Mepron	atovaquone
Myambutol	ethambutol
Mycobutin	rifabutin
Paser	para-aminosalicylic acid
Pyridoxine	vitamin B6
Rifadin	rifampin
Seromycin	cycloserine
Sporanox	itraconazole
Tebrazid	pyrazinamide
Trecator	ethionamide
Trimethoprim	
Valcyte	valganciclovir HCL
Zithromax	azithromycin
Zovirax	acyclovir

Adjuvant Therapy

Hydrea	hydroxyurea
Megace	megestrol Acetate
Procrit	epoetin alfa
Wellcovorin	leukovorin

Hepatitis C Tre atment

Peg-Intron	peginterferon-alfa 2b**
Rebetol	ribavirin

Vaccines

Hepatitis A
Hepatitis B
Hepatitis A/B
Pneumovax

*Only for those persons currently prescribed Invirase; all others will be provided Fortovase unless a medication exception is requested.

**Monthly prescriptions needed as well as medication exception.

Obtaining Medications

Prescriptions and other information will be needed at the local health department. Clients must present these items to the eligibility clerk at their local health department. To prevent delays in getting prescriptions filled, PLEASE have the client call ahead to find out when eligibility is being conducted and what information will be needed. It may take up to 7 days (one week) to receive medications after the paperwork has been reviewed.

Once clients have been enrolled in ADAP, they will need to be provided with new prescriptions and information (date and most recent CD4/viral load) for all anti-HIV medications (NRTI, NNRTI, PIs) every 6 months. New prescriptions for all other medications like Bactrim or azithromycin are needed only once a year.

Other Resources

1. To access the Pharmaceutical Manufacturers Association Indigent program, your office must call 1-800-PMA-INFO to request information.

2. Information about treatment (drug studies) is available by calling 1-800-TRIALS-A.

3. Information about approved treatments is available by calling 1-800-HIV-0440.

4. Health care providers who have clinical questions may contact their Regional AIDS Resource and Consultation Centers:

Central:	800-525-7605 804-828-2210
Eastern:	800-999-8385 757-446-6170
Northern:	800-828-4927
Northwest:	800-421-1102
Southwest:	800-950-4056

For the health and safety of our clients, please encourage patients to obtain new prescriptions or inform the health department of the need prior to running out of medications. Delays will place their health at risk

VIRGINIA DEPARTMENT OF HEALTH

ADAP MEDICATION EXCEPTION FORM

Medication Request #1 ____ #2____ #3rd___ #4_____

PATIENT NAME:_____
Last **First** **MI**

DATE OF BIRTH_____/_____/_____ **AGE**_____
mm **dd** **yr**

SEX: ____ ☐ **Male** ☐ **Female**

RACE/ETHNICITY:

_____ African-American/Black, (non-Hispanic)
_____ Aleutian
_____ American Indian
_____ Asian/Pacific Islander,
_____ Eskimo
_____ Hispanic
_____ Unknown
_____ White (non-Hispanic)

HEALTH DEPARTMENT_____

HEALTH DEPARTMENT ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

HEALTH DEPT. PHONE #:_____

HEALTH DEPT. FAX #:_____

HEALTH DEPARTMENT CONTACT PERSON:_____

PRESCRIBING PHYSICIAN NAME:_____

PHYSICIAN PHONE #:_____

FORM COMPLETED BY:_____

TITLE:_____ **DATE:**_____

REASON FOR REQUEST
(Please check all that apply)

Patient Name_____

A. DRUG INTOLERANCE:

_____ **Abdominal Pain**
_____ **Diarrhea**
_____ **Elevated blood glucose**
_____ **Fatigue**
_____ **Fever**
_____ **Headache**
_____ **Hyperlipidemia**
_____ **Increased thirst**
_____ **Itching**
_____ **Lypodystrophy**
_____ **Nausea**
_____ **Neuropathy**
_____ **Numbness**
_____ **Pancreatitis**
_____ **Rash**
_____ **Renal Calculi**
_____ **Renal Failure**
_____ **Vomiting**
_____ **Other**_____

B. TREATMENT FAILURE\DISEASE PROGRESSION

- ☐ **Increasing viral load, ⇒.5 log**
- ☐ **Decreasing CD4 levels**

C. ADHERENCE ISSUES:

- ☐ **Work schedule**
- ☐ **Clinical preference**
- ☐ **Lifestyle Issues**
- ☐ **Previous compliance Hx:**
- ☐ **Difficulty with instructions**

D. LIMITED TREATMENT OPTIONS:

- ☐ **protease inhibitor resistance**
  Documented by _____
- ☐ **antiretroviral resistance**
  Documented by:_____
- ☐ **drug combination failure**
  Documented by:
- ☐ **Is this salvage therapy?**

Drug Requested:_____ **Date:**_____

New drug combination will include_____

VDH USE ONLY

Request Approved By_____ **Date** _____ **Request Denied By**_____ **Date**_____

Rational:

_____

Date Sent to Pharmacy_____
Date LHD Contact_____

Patient Name_____

LABORATORY HISTORY

Please start with the most current results (give at least two (2) results if available)

VIRAL LOAD RESULTS	DATE	CD4 COUNT RESULTS	DATE

ANTIRETROVIRAL HISTORY DATE INITIATED/DISCONTINUED*

Do not include requested medication. Include medication from 1998 and up.

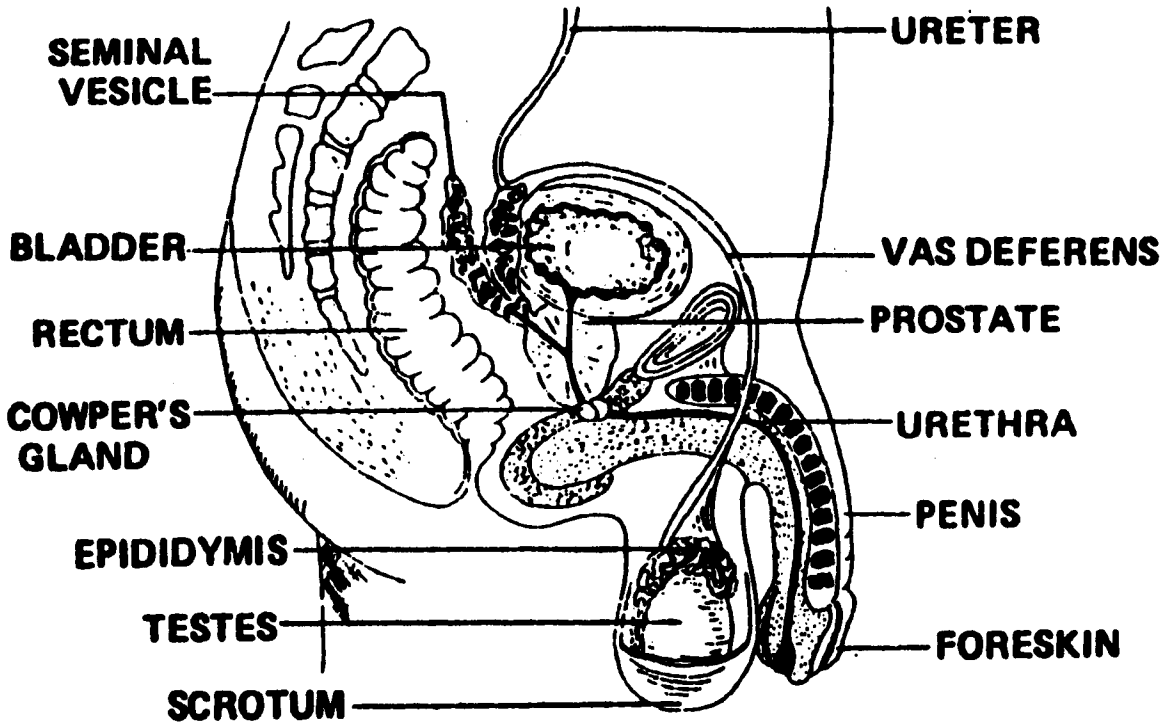
DRUG	DOSAGE	DATE INITIATED	DATE DISCONTINUED	REASON DISCONTINUED

- *TO INCLUDE NUCLEOSIDE AND NON-NUCLESIDE ANALOGUES, PROTEASE INHIBITORS

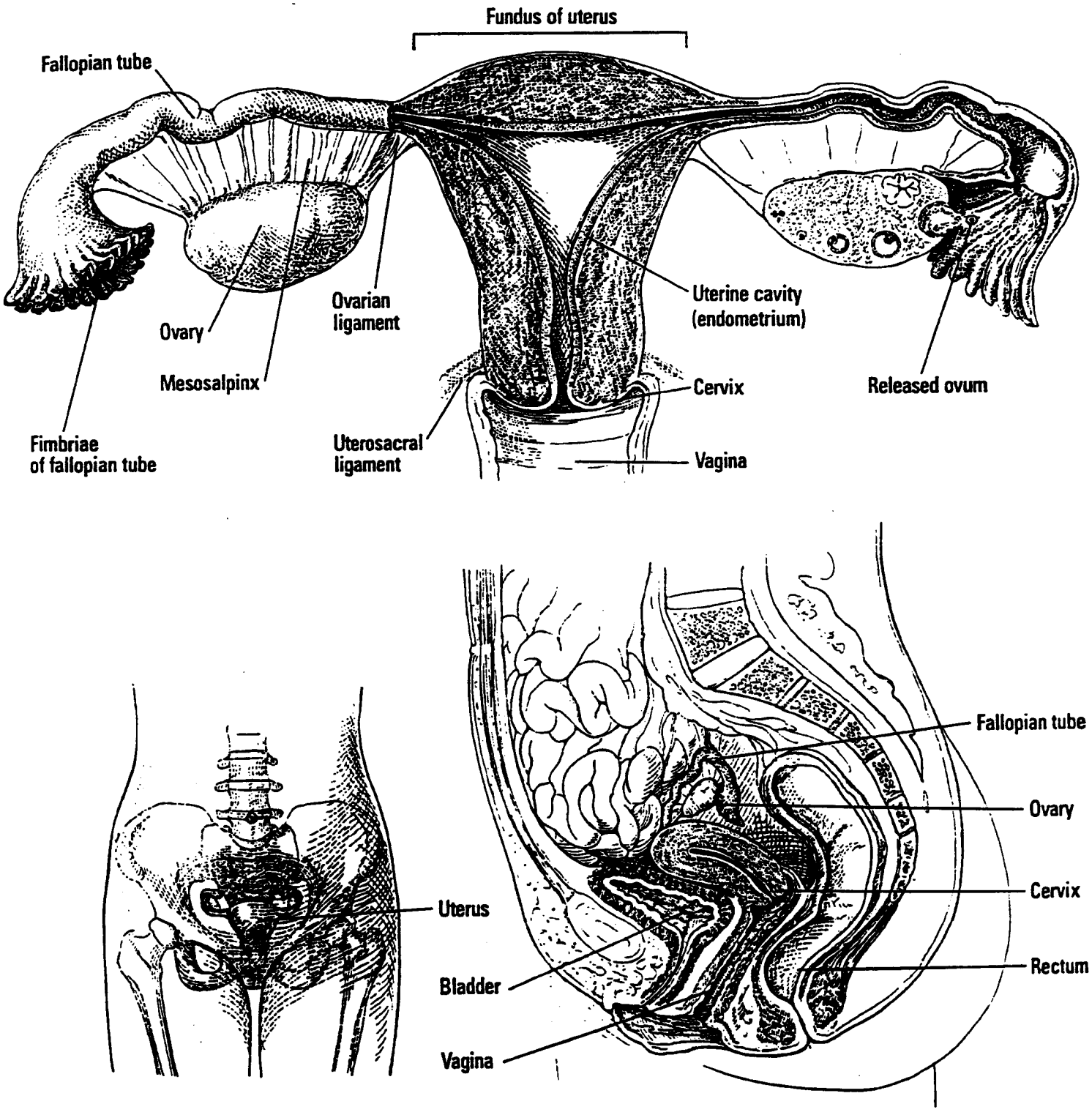
Sexually Transmitted Infections at a Glance

STD	Chlamydia	HPV	Genital Herpes	Lice	Gonorrhea (GC)	Syphilis	Trichomonas
Caused By	Caused by Chlamydia trachomatis (bacteria) 3-5 million cases/yr in US; affects 10% students	"Genital Warts' Caused by the Human Papilloma Virus ≈ 3 million infections/yr	Caused by Herpes Simplex 2 Virus (lives dormant in the nerve cells) in U. S. >25 million people infected 300,000-500,000 new cases each year	Caused by pubic lice (small wingless insect)	Caused by Neisseria gonorrhea (bacterium) 3 million/year in US	Caused by Treponema Palladium (spiral bacteria)	Caused by protozoa
How Transmitted	Sexual intercourse (it has to live in cells – male urethra or female cervix)	Sexual contact (the virus lives in the skin cells on the penis, scrotum, vagina, vulva, cervix, or around anus)	Genital/genital contact; oral/genital contact; more rarely, skin to lesion contact SKIN to SKIN	Skin to skin contact	Sexual intercourse involving body fluids (semen, vaginal & cervical secretions	Contact between lesion and mucus membranes or break in skin	Almost always – sex Rarely – wet bathing suits, towels
Incubation Period	1 – 3 weeks	Weeks to months (can be > 1 year)	2 - 20 days or longer Initial 1 – 3 week	1 month after infestation	3 – 7 days	10 – 90 days average 17 – 21 days	1 week – 3 months
Signs and Symptoms	**Male** – discharge, burning w/urination, lymph node swelling **Female** – mild discharge, up to 75% without symptoms	May develop visible, painless warts on penis, vulva, vagina, around anus; many microscopic; Possibly no symptoms	episode painful blisters mild or no symptoms recurrent episodes milder; can be transmitted without symptoms	Itching: may develop rash in public area	**Male**- white or yellow penile discharge; burning w/urination; 40% no symptoms **Female** – vaginal discharge; 80% no symptoms	*Primary* - chancre (open sore on genitals-painless) *Secondary* - rashes, *Latent* – no symptoms *Tertiary* - organ destruction	**Female**- 80- 90% no symptoms; vaginal burning & itching; yellow discharge; pain with intercourse **Male** – 99% no symptoms
Diagnosis	Urethral or cervical swab (2-3 days)	Visible wart like lesions. May show in Pap smear.	Culture of blister	Visual (look for lice & nits)	Culture	Blood test	Look at discharge under microscope
Treatment	Antibiotics; all sexual partners treated	Cryotherapy, laser, chemical treatment; frequent recurrences; all sexual partners checked	No cure; antiviral (Acyclovir) can help lessen symptoms	Kwell shampoo; washing clothes and linens in hot water	Antibiotics; all sexual partners treated	Antibiotics; all sexual partners treated	Antibiotics; all sexual partners treated
Complications	**Male** – Epididymitis (swelling of testicles) **Female** – PID **Babies** – eye infection or pneumonia if mother infected at delivery	**Female** – precancerous changes on the cervix **Male** – Urethral obstruction if warts are in urethra	**Babies** – transmission to baby during childbirth if mother has outbreak; avoidable with caesarian section	NONE	**Male** – sterility **Female** – sterility or ectopic pregnancy **Babies** - pneumonia, eye infections if mother infected	**Babies** - passed during pregnancy **Tertiary syphilis** – blindness, deafness, insanity, crippling	NONE

The Male Reproductive System



Testes- two organs where sperm and male hormones are produced
Scrotum- sac controlling the temperature of the testes
Epididymis- two sets of tubes connecting testes to the vas deferens
Vas Deferens- two sperm ducts leading from the epididymis to the seminal vesicles
Seminal Vesicles- two pouches that produce food and fluid for the sperm
Prostate- gland that produces alkaline fluid for the sperm
Cowper's Glands- two glands that secrete two or three drops of fluid prior to ejaculation
Penis- male organ of copulation and urination
Urethra- duct that carries urine or semen from the male body


Fundus of uterus
Fallopian tube
Ovary
Mesosalpinx
Ovarian ligament
Uterine cavity (endometrium)
Cervix
Released ovum
Fimbriae of fallopian tube
Uterosacral ligament
Vagina
Uterus
Fallopian tube
Ovary
Cervix
Rectum
Bladder
Vagina

CHLAMYDIA

COMMONWEALTH of VIRGINIA

E. Anne Peterson, MD, MPH
State Health Commissioner

Department of Health
P O BOX 2448
RICHMOND, VA 23218

TDD 1-800-828-1120

MEMORANDUM

DATE: January 19, 2000

TO: District Directors

FROM: Casey W. Riley, Director
Division of HIV/STD

Barbara Parker, Women's Health Nurse Consultant
Division of Women's and Infant's Health

SUBJECT: Chlamydia Testing for Male Partners of Infected Females

With the support of the Centers for Disease Control and Prevention, Virginia's Chlamydia Prevention Program expanded its screening criteria in our STD, family planning, and prenatal clinics. Since October 1, 1997, male partners of infected females were eligible for screening and services through the Chlamydia Prevention Program.

From October 1, 1997 through March 31, 1998, 1576 males were screened. Only 16% of these males, however, were marked as "contact" in the reason for exam data field. This suggests that 84% of the males tested were outside of the program screening criteria or that clinic staff marked a reason for exam other than "contact." (For those marked as "contact", 24% tested positive for chlamydia.)

It will be difficult to maintain funding at current screening levels in all of our clinic sites, if the screening guidelines are not followed. Every effort should be made to assure that program funds are not spent to screen individuals who fall outside the screening criteria. Please remind clinic staff that only male partners of infected females are to be tested, and to mark "contact" in the reason for exam data field for these male patients.

The Chlamydia Program recognizes clinicians' interest in including all males in their screening activities. Our federal funding source, however, restricts screening to females and male partners of infected females only. Attached is a copy of the current screening criteria, which you may wish to post in your clinics.

Thank you for assisting us in maximizing program services though continued monitoring of this select male population. If you have questions or concerns, please contact Trinita Pascal, Chlamydia Program Coordinator at (804) 786-3212.

CWR/BP/agc
Attachment

CHLAMYDIA PREVENTION PROGRAM SCREENING CRITERIA

- Females under 35 visiting STD clinics who are receiving a pelvic examination

- Females under 30 in family planning clinics who are receiving a pelvic examination

- All prenatal clinic patients

- Male partners of infected females

GONORRHEA

00-599

Guide for the
DIAGNOSIS of GONORRHEA
Using Culture & Gram-Stained Smear

(Formerly "Criteria and Techniques for the Diagnosis of Gonorrhea")

July 1991

CDC
CENTERS FOR DISEASE CO

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • Public Health Service • Centers for Disease Con
• National Center for Prevention Services • Division of STD/HIV Prevention and National Center for Infectious Disea
• Division of Sexually Transmitted Diseases Laboratory Research • Atlanta, GA 30333

INTRODUCTION

Gonorrhea remains a disease of considerable importance in the United States and throughout the world. The accurate diagnosis of gonorrhea is crucial to the management of individual patients and to the control of this disease in the community. This document focuses on the laboratory methods available to assist the clinician in diagnosing gonorrhea, i.e., Gram-stained smear, bacteriologic culture, and confirmatory identification.

N. gonorrhoeae infects various anatomic sites and causes many different manifestations of disease that can only be summarized here. The reader is encouraged to consult published accounts for more specific details about these issues.

For further information:
Centers for Disease Control
Attn: National Center for Prevention Services
Division of STD/HIV Prevention
Mail Stop E02
Atlanta, Georgia 30333

Telephone: (404) 639-2580

or

Centers for Disease Control
Attn: National Center for Infectious Diseases
Division of Sexually Transmitted Diseases
Laboratory Research
Mail Stop D13
Atlanta, Georgia 30333

Telephone: (404) 639-3470

Recommended techniques for obtaining and handling culture specimens are presented in the text.

INDICATIONS

I. WOMEN

A. Whenever a reasonable risk of infection exists and the opportunity presents, any sexually active woman should be tested for *N. gonorrhoeae* using a selective culture medium.*

B. Women who are suspected of having a gonococcal infection should be examined and have endocervical specimens tested for *N. gonorrhoeae* without regard for the day of the menstrual cycle. Anal cultures, in addition, may increase the yield of positives.

C. Gram-stained direct smears of endocervical specimens may be useful when gram-negative intracellular diplococci are identified, but are not sensitive enough to *rule out gonorrhea.* When well-trained personnel identify gram-negative diplococci within polymorphonuclear leukocytes in a smear of an endocervical canal specimen, a presumptive diagnosis for gonorrhea can be made and treatment initiated. However, smears cannot be substituted for the culture as the only diagnostic test.

D. A repeat culture 4-7 days after completion of therapy will detect treatment failures but is not essential if the recommended regimen of ceftriaxone plus doxycycline is used. Chlamydial infections coexist with high frequency in persons with gonorrhea; thus, patients should be treated simultaneously with antimicrobials effective for both *Chlamydia trachomatis* and *N. gonorrhoeae.* A test-of-cure examination may include an endocervical Gram-stained direct smear, but must include the culture of specimens obtained from both the endocervical and anal canals, inoculated on selective media, preferably using separate plates. (see TECHNIQUES, Items I.A.1 and A.2).

E. Oropharyngeal cultures (inoculated on a selective medium), in addition to anogenital cultures, should be performed for all women with disseminated gonococcal infection or who are suspected of having a pharyngeal gonococcal infection, e.g., those who practice fellatio. Gram-stained direct smear should not be used to test specimens from the pharynx.

F. Specimens for culture from the urethra and rectum are indicated in adult females when the endocervix is absent, e.g., total hysterectomy patients.

II. MEN

A. When urethral gonococcal infection is considered in men with or without symptoms or signs, a specimen should be collected for a Gram-stained direct smear. Gram-stained direct smear sensitivity is less when urethral gonorrhea is asymptomatic. A culture should be obtained if gram-negative intracellular diplococci cannot be identified on direct smear, when urethral exudate is absent, or when a possible case has medicolegal implications. Typical gram-negative diplococci found only outside polymorphonuclear leukocytes may or may not be gonococci; therefore, culture the urethral specimen on a selective medium. If antibiotic resistance is suspected, a culture is necessary regardless of the Gram stain results; or if correlations of Gram-stained direct smears and culture are maintained as a quality control measure, specimens for culture should be obtained regardless.

B. Men who are suspected of having gonorrhea and whose sexual practices may have exposed them at the rectum or pharynx should have these sites cultured. Specimens from different sites should be inoculated on separate plates of selective media.

C. A repeat culture 4-7 days after completion of therapy will detect treatment failures but is not essential if the recommended regimen of ceftriaxone plus doxycycline is used. Chlamydial and gonococcal infections coexist with high frequency; thus, patients should be treated simultaneously with antimicrobials effective for both *Chlamydia trachomatis* and *N. gonorrhoeae.* A Gram-stained direct smear is not recommended as the exclusive test to conclude that men are cured. All anatomical sites found to be infected before therapy should be retested.

III. PREPUBERTAL CHILDREN

A. A prepubertal child should be tested for gonorrhea when symptoms or signs suggest gonococcal infection and/or when it is judged that the child may have been exposed to disease. The procedures for collecting specimens from prepubertal children are set forth in TECHNIQUES.

*Selective media include Martin-Lewis (ML), Modified Thayer-Martin (MTM), or New York City (NYC) media. For information on these media, see:

1 Martin JE Jr and Lewis JS Anisomycin:Improved antimycotic activity in modified Thayer-Martin medium. Public Health Lab 1977;35:53-62.

2 Martin JE Jr, Armstrong JH and Smith PB: New System for the cultivation of *Neisseria gonorrhoeae.* Appl Microbiol 1974;4:802-805.

3 Faur YC, Weisburd MH, Wilson ME and May PS: A new medium for the isolation of pathogenic *Neisseria* (NYC Medium). Health Lab Sci 1973;10:44-74.

B. A Gram-stained direct smear of vaginal exudate in females and of urethral exudate in males may be of benefit in the timely administration of therapy for prepubertal children. However, diagnosis of gonorrhea in this and in other medicolegal situations should be based on culture on a selective medium, followed by confirmatory procedures (see SPECIAL SITUATIONS, Item III).

C. A test-of-cure culture 4-7 days following the completion of therapy is recommended for all prepubertal children having gonorrhea. The test-of-cure should include specimens collected from all previously infected sites. A Gram-stained direct smear may be used when symptoms persist, but a culture should also be performed to confirm test-of-cure results.

TECHNIQUES

I. CULTURE SPECIMEN COLLECTION

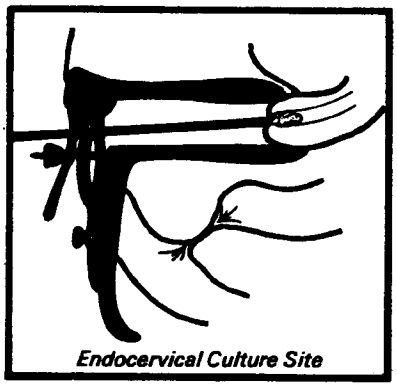
A. WOMEN

1. Endocervical Canal *(the most sensitive site to culture for screening purposes)*

a. Moisten the speculum with warm water (do not use any other lubricant), insert the speculum, and visualize the cervix.

b. Data* suggest that it is necessary to remove excess cervical mucus before collecting a specimen for gonorrhea culture.

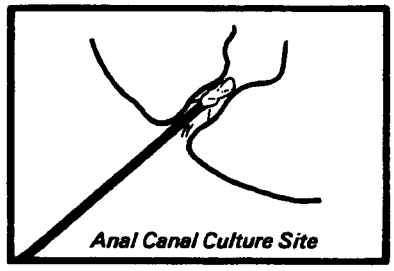
c. Insert a sterile cotton-tipped swab into the endocervical canal and allow reasonable time (e.g., 15-30 seconds) for secretions to absorb.


Endocervical Culture Site

Note: The recovery of *Chlamydia trachomatis* in cell culture is improved by removal of the cervical mucus, and this should be done when a specimen for this test is also being collected from a patient examined for gonorrhea. If multiple tests are being taken, the recommended order is the first swab for vaginal wet preparations, second for cleaning the cervix, third for gonorrhea smear and culture, and fourth for chlamydia. If a Pap smear is to be done as well, it can be taken anytime after the cervix has been cleaned.

2. Anal Canal

Note: This specimen can easily and adequately be obtained without using an anoscope. Insert a sterile cotton-tipped swab approximately 2-3 cm into the anal canal, exerting lateral pressure, and allow reasonable time (e.g., 15-30 seconds) for secretions to absorb.


Anal Canal Culture Site

*Oxtoby MJ, Arnold AJ, Zaidi AA, Kleris GS, and Kraus SJ: Potential shortcuts in the laboratory diagnosis of gonorrhea: a single stain for smears and nonremoval of cervical secretions before obtaining test specimens. Sex Transm Dis 1982; 9:59-62.

3. Urethra

Massage the urethra against the pubic symphysis or strip the urethra toward its orifice to express exudate. Use a calcium alginate swab to obtain the specimen.

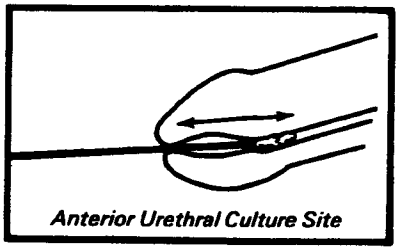
4. Oropharynx

Swab the posterior pharynx and tonsillar crypts with a sterile cotton-tipped applicator.

B. MEN

1. Urethra

Exudate expressed into the urethral meatus can be transferred to the selective culture medium with a sterile cotton swab. When exudate is not demonstrated, a specimen should be obtained using a calcium alginate swab inserted 2-3 cm into the anterior urethra.


Anterior Urethral Culture Site

2. Anal Canal

This culture can be taken in the same manner as for "WOMEN," Item 2.

3. Oropharynx

This culture can be taken in the same manner as for "WOMEN," Item 4.

C. PREPUBERTAL CHILDREN

Because of the trauma involved, a vaginal speculum examination in a prepubertal female is not recommended to obtain a culture specimen. The specimen should be obtained from the vaginal vault by separating the labia, manually exposing the introitus, and using either a cotton swab or a calcium alginate swab. Specimens for cultures may be taken from prepubertal males according to the procedures described for adult males, except that the swab should be inserted no more than 1 cm into the urethra. All definitive isolates of *N. gonorrhoeae* from a prepubertal child should be confirmed by two tests based on different principles (e.g., carbohydrate utilization, rapid enzyme substrate tests, serologic methods such as fluorescent antibody tests or coagglutination, or DNA probe technique).

II. STORAGE AND INOCULATION OF SELECTIVE MEDIUM CULTURE PLATES

A. STORAGE

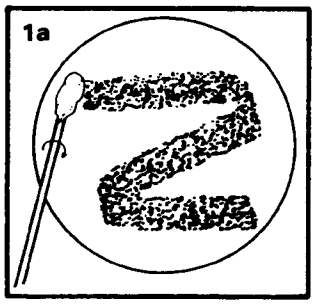
Store plates sealed in plastic sleeves in the refrigerator; place the plates in an *inverted* position (bottom, or medium side up). Medium should be used before the expiration date and be *at room temperature* before inoculation. The medium surface should be smooth, glistening, and free of excessive moisture. Dried medium that has pulled away from the sides, has cracked, or has a wrinkled surface should not be used.

B. INOCULATION

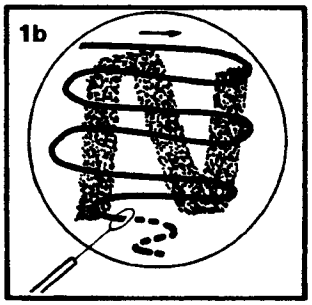
1. For screening purposes, acceptable results may be obtained from inoculating a single divided plate of selective medium with two specimens from the same site (e.g., endocervix) or a biplate with specimens from the endocervix and the rectum. Data suggest that dual specimens from one site may offer improved detection and that the dual plating technique may offer economic advantages and acceptable results when the

patient to be screened has specimens taken from both the endocervix and rectum. A divided plate is not recommended for test-of-cure; however, data indicate that the procedure is less sensitive than using separate plates with patients who are positive only at the rectum on test-of-cure.

2. *Roll* swab in a large "Z" pattern on a 100 mm plate containing selective medium (see 1a). Cross-streak immediately with a sterile wire loop or the opposite end of the sterile swab *in the clinical facility* (see 1b).

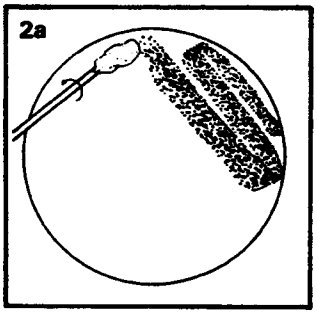


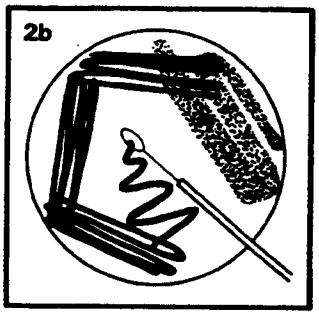
"Z" Pattern Primary Inoculation



Cross-Streaked

3. An alternative procedure is to roll the swab over a 20-25% segment of the medium surface. Cross-streak the media using the standard microbiologic procedure for colony separation (see 2a and 2b).





4. When inoculating a divided plate with specimens from separate sites, identify the sites by using different procedures to roll each swab so the laboratory can accurately report the infected site if only one side of the plate is positive.

III. HANDLING OF INOCULATED SELECTIVE CULTURE MEDIUM PLATES

A. THE CANDLE JAR SYSTEM

Do *not* place *inoculated* medium in the refrigerator or expose it to extreme temperatures.

1. Place the culture plate in a CO_2-enriched atmosphere (e.g., candle jar) within 15 minutes of inoculation. Be sure to light the candle each time the jar is opened. *As the jar fills with inoculated culture plates, position the candle to avoid any risk that the plates will be melted or that the candle will be prematurely extinguished by the lid.*

2. Put the jar in the incubator as soon as possible, certainly within 1-2 hours after inoculation, and incubate at 35°- 37° C.

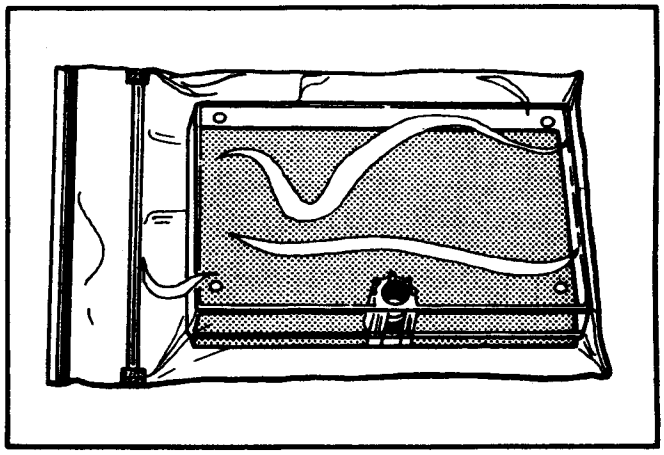
B. THE CO_2 TABLET/PLASTIC BAG SYSTEM

Several systems now use a CO_2-generating tablet to create a CO_2-enriched atmosphere in a closed container (e.g., plastic bag with ≥ 0.002 inch thickness to prevent the loss of CO_2).

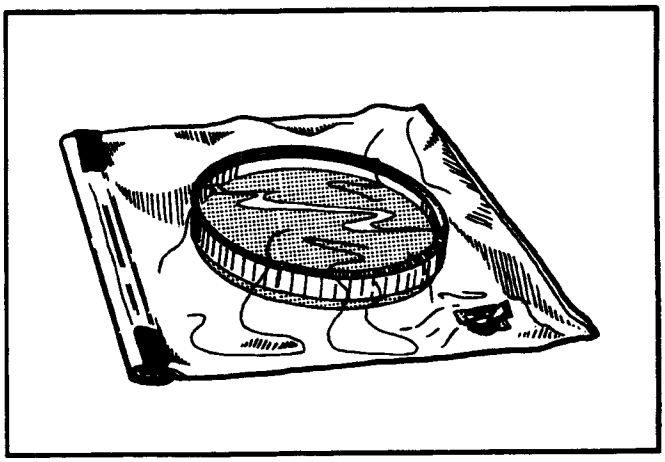
1. Place the culture plate in CO_2-enriched atmosphere (e.g., plastic bag) within 15 minutes of inoculation.
   a. If using the Biological Environmental Chamber (BEC) system, remove the CO_2-generating tablet from the foil and place it in the well of the plate. *Do not place the tablet directly on the medium surface.* Place the closed plate in the plastic bag and seal tightly.
   b. The "Bag and Tablet" method will create the needed CO_2 atmosphere. Using only foil-wrapped CO_2-generating tablets, tear just enough to expose the tablet prior to placing foil and tablet in the bag. The tablet should not be handled directly to avoid transferring staphylococci or other organisms to it that may be present on the hands. Leaving the tablet in the foil avoids contamination and also eliminates the residue problem previously encountered with the naked tablet. If the bag is reopened, insert a new tablet.

2. Expel excess air from the bag itself and seal it tightly. *Check to make sure that no portion of the bag is left open.* It is not necessary to drop water on the pill to initiate CO_2 production as moisture from the medium will activate the CO_2-generating tablet.

3. Incubate within 1-2 hours after inoculation at 35°-37° C.



Biological Environmental Chamber



Bag and Tablet (Exposed in Foil)

IV. GRAM-STAINED SMEAR

A Gram stain of a smear of urogenital secretion has been utilized for over 70 years for presumptive diagnosis of gonococcal infections of the male urethra and the female cervix. Sites for use of the Gram stain and representative published estimates of its sensitivity and specificity are summarized below.

Patient's Sex	Anatomic Site	Clinical State	Sensitivity	Specificity
Male	Urethra	Discharge	95%	97-99%
		No discharge	70%	97-99%
Female	Cervix	All	30-65%	90-97%

To collect a specimen for Gram-stained direct smear, follow the procedures outlined in the previous section on culture specimen collection, specifically "WOMEN," Item 1 and Item 3, and "MEN," Item 1. A specimen collected for culture can be used for Gram stain as well. First, prepare the smear by *rolling* the swab on the slide. Do *not* rub the swab on the slide because microscopic morphology can be distorted. If leukocytes are disrupted, the location of the diplococci, i.e., intracellular vs extracellular, may be difficult to determine. After the slide for Gram stain has been prepared, inoculate the selective medium culture with the same swab.

Before staining a direct smear, the slide should be allowed to air dry (2-5 minutes, depending on the thickness of the smear) and be heat-fixed by passing it several times through the flame of a Bunsen or alcohol burner. The slide should be only slightly warm to the skin when touched to the back of the hand.

CRITERIA

CERTAINTY OF DIAGNOSIS

Criteria are listed for several possible levels of certainty for the diagnosis of gonorrhea: definitive, presumptive, and suggestive. Meeting the criteria for a definitive diagnosis represents the highest level of confidence. A presumptive diagnosis, while not definitive, reflects a sufficient level of confidence to warrant full treatment and followup. Suggestive criteria, e.g., history of exposure, cervical motion tenderness, adnexal tenderness, etc., do not confirm the diagnosis but are useful in patient management. Here, the potential benefit of treatment must be weighed against the risk of withholding or delaying it. Whenever a suggestive diagnosis is made, the clinician should always attempt to obtain laboratory evidence for a presumptive or definitive diagnosis.

I. UNCOMPLICATED GONOCOCCAL URETHRITIS, ENDOCERVICITIS, PROCTITIS, AND PHARYNGITIS

A. Definitive diagnosis is the same for all age groups, both sexes, and all sites (except for prepubertal children for whom more extensive procedures are necessary - see SPECIAL SITUATIONS for qualifications on the use and interpretation of confirmation tests). A definitive diagnosis must be based on (1) isolation of *N. gonorrhoeae* from sites of exposure by culture (usually selective medium) and demonstrating typical colonial morphology, positive oxidase reaction, and typical gram-negative morphology and (2) confirmation of isolates by biochemical, enzymatic, or nucleic acid testing (e.g., carbohydrate utilization, rapid enzyme substrate tests, serologic methods such as fluorescent antibody testing or coagglutination, or DNA probe technique).

B. Presumptive culture diagnosis applies only to adult anorectal and genitourinary sites. It must include typical colonial morphology on selective culture medium, positive oxidase reaction, and typical gram-negative morphology.

C. Presumptive diagnosis using Gram-stained direct smear applies only to adult males tested from the urethra and adult females tested from the endocervix. It must include typical gram-negative intracellular diplococci on direct Gram-stained smear, read by well-trained personnel.

D. Suggestive diagnosis is a minimum level of certainty and is based on sexual exposure to a person infected with *N. gonorrhoeae* and mucopurulent endocervical or urethral exudate on physical examination.

II. ANTIBIOTIC RESISTANT *N. GONORRHOEAE*

Gonococcal infections caused by antimicrobial-resistant gonococci are clinically indistinguishable from those caused by susceptible strains. The early recognition of resistant organisms in a community, however, makes intervention efforts more effective. The early detection of resistant organisms will indicate the need to evaluate the effectiveness of currently used therapies and guide the choice of an alternative therapy should the need arise. Ideally, the routine surveillance of a sample of isolates for antimicrobial resistance will provide the most timely indication of the need to reevaluate control measures. At the least, the CDC recommends that isolates from patients whose infection persists after therapy should be tested for antimicrobial resistance. Alternatively, the occurrence of a cluster of apparent treatment failures in a short period of time should alert health care providers of the possible occurrence of an outbreak caused by resistant isolates. When such outbreaks occur, a sample of isolates should be tested for antimicrobial resistance.

Antimicrobial-resistance occurs in two forms in *N. gonorrhoeae*. First, resistance to a wide range of antimicrobial agents occurs due to chromosomal resistances, i.e., resistances that are intrinsic to the genetic makeup of the organism and which are very rarely transferred to other gonococcal strains. Single and multiple chromosomal resistances may occur to penicillin, tetracycline, spectinomycin, cefoxitin, or related antimicrobials. These isolates are called chromosomally mediated resistant *N. gonorrhoeae* (CMRNG). CMRNG are regarded as important because most isolates also show decreased susceptibility to ceftriaxone and related antibiotics which may portend emerging resistance and may result in future clinical treatment failure with these antimicrobials. The degree of antimicrobial resistance among CMRNG is quite broad, ranging from measurable, but clinically unimportant resistance, to resistance sufficient to cause treatment failure.

The second form of antimicrobial resistances in *N. gonorrhoeae* are plasmid-mediated resistances to penicillin and tetracycline. The genes determining these resistances are located on genetic material, a plasmid, unassociated with the bacterial chromosome. These resistances may be transmitted to other gonococcal strains by cell-to-cell contact. The degree of resistance to penicillin and tetracycline are higher with plasmid-mediated resistance than with chromosomally determined resistances. Strains with plasmid-mediated resistance to penicillins are called penicillinase-producing *N. gonorrhoeae* (PPNG; also called ß-lactamase-producing *N. gonorrhoeae*). Those with tetracycline resistance *N. gonorrhoeae* are called TRNG. Strains with plasmid-mediated resistance to *both* penicillin and tetracycline are called PPNG, TRNG. The resistance to penicillin and tetracycline mediated by plasmids is clinically significant as most patients will fail therapy with penicillin and tetracycline group antimicrobials if infected with one of these strains.

Anticipated failure rates with strains possessing chromosomal and plasmid-mediated resistance are difficult to assess when dual therapy is used. Traditionally, failure rates have been measured in clinical trials in which patients are treated with only one antimicrobial agent. The level of in vitro resistance measured by susceptibility testing that corresponds to clinical treatment failure has been determined in clinical studies to provide criteria for the interpretation of susceptibilities derived by laboratory testing. These studies indicate that infections caused by isolates with chromosomal resistances (CMRNG) usually have a failure rate of approximately 15% when patients are treated with the corresponding antimicrobial alone. The exception is infections caused by spectinomycin-resistant isolates which may have failure rates approaching 100% when patients are treated with spectinomycin alone. Failure rates for strains with plasmid-mediated resistance vary according to the type of plasmid; for PPNG infections, the failure rate may vary from 25% to 60% when patients are treated with single-dose penicillin therapy. The anticipated failure rates determined for single-dose therapies do not apply to the clinical outcome expected for currently recommended dual therapies for gonorrhea and chlamydia since doxycycline may be very effective against many PPNG infections and infections caused by spectinomycin-resistant isolates, which may still be sensitive to tetracycline.

A. PENICILLINASE-PRODUCING *N. GONORRHOEAE*

1. Definitive diagnosis of PPNG infection requires a definitive culture diagnosis for *N. gonorrhoeae* plus documented penicillinase production in a pure culture according to a specific test. Three types of acceptable tests are available for use: (a) acidometric, (b) iodometric (including the starch paper technique), and (c) chromogenic cephalosporin assays. All β-lactamase tests operate on the hydrolysis of a substrate, although the particular substrate and method of detection varies. These tests work on the principle that when the β-lactam (penicillin) or cephalosporin molecules are attacked by the enzyme, β-lactamase, an acidic product is formed which is detected by different methods. In the acidometric test, the acid product is directly detected by the acidification of a pH indicator, phenol red, which turns from orange to red. In the iodometric test, the acid product hydrolyzes the starch which, in turn, gives a purple reaction with the iodine reagent in the test. In the chromogenic cephalosporin test, the acid product is red in contrast to the original yellow-orange substrate.

   All three tests may be performed by taking a colony of the isolate to inoculate the test. The Cefinase (chromogenic cephalosporin) and starch iodine disk tests are routinely performed this way and are specific and sensitive if executed correctly. Tests performed in solutions (starch iodine and acidometric) may require a larger inoculum to be as sensitive as the disk tests and, thus, may require pure cultures obtained by subculturing to ensure a sufficient number of colonies for the inoculum.

2. Presumptive laboratory diagnosis of PPNG infection is based on a presumptive culture diagnosis of *N. gonorrhoeae* plus a positive penicillinase test.

3. Presumptive clinical diagnosis of PPNG is reached when:
   a) A patient presumed to have gonorrhea (see previous section) has a sexual partner with definitive or presumptive PPNG.
   b) A patient presumed to have gonorrhea has recently traveled to a region where PPNG is highly prevalent.

4. Suggestive diagnosis of resistant gonorrhea due to PPNG is reached when:
   a) Any gonorrhea patient treated with penicillin/ampici tetracycline regimen is not cured.
   b) The patient meets the criteria suggestive of unc plicated gonorrhea and has a sexual partner with de tive or presumptive PPNG or history of recent trav a region where PPNG is highly prevalent.

B. CHROMOSOMALLY MEDIATED RESISTANC (PENICILLIN)

1. Definitive diagnosis of CMRNG infection is based on treatr failure of culture-confirmed gonorrhea with regimens of pe lin/ampicillin and tetracycline, a negative β-lactamase test, resistance to penicillin *and* tetracycline. Resistance ma determined by agar dilution (MIC ≥ 2.0 µg/ml to penicillin tetracycline) or disk diffusion (zone sizes: penicillin ≤ 26 mm tetracycline ≤ 30 mm) susceptibility tests.

2. Presumptive laboratory diagnosis of CMRNG is based on sumptive culture diagnosis of gonorrhea (see previous sect a negative penicillinase test, and a positive disk diffusion

3. Presumptive clinical diagnosis of CMRNG infection is rea when a patient presumed to have gonorrhea (see pre section) has a sexual partner with a definitive or presum diagnosis of CMRNG or when a patient is not cured with cillin and tetracycline gonorrhea therapy and the PF specific test is negative.

C. CHROMOSOMALLY MEDIATED RESISTAI (SPECTINOMYCIN)

1. Definitive diagnosis of spectinomycin-resistant infection is b on treatment failure of culture confirmed gonorrhea with tinomycin and a positive disk diffusion test for spectinor resistance (zone size ≤ 14 mm). Spectinomycin-resi strains may also be β-lactamase-positive and CMRNG; th highly effective gonorrhea therapy, such as ceftriaxone, s be administered when spectinomycin-resistant infection diagnosed.

2. Presumptive laboratory diagnosis of spectinomycin-resist is based on presumptive culture diagnosis of gonorrhea previous section) and a positive test for spectinomycin tance (zone size ≤ 14 mm).

3. Presumptive clinical diagnosis of spectinomycin-resista fection is reached when a patient presumed to have gono (see previous section) has a sexual partner with a definit presumptive diagnosis of spectinomycin-resistant infecti when a patient is not cured with spectinomycin.

D. HIGH-LEVEL TETRACYCLINE RESISTANCE

1. Definitive diagnosis of TRNG infection is based on trea failure of culture-confirmed gonorrhea with a tetracycline men and a positive disk diffusion test for high-level tetrac (zone size ≤ 19 mm) resistance. The only definitive labo test for TRNG is detection of the tetM determinant (the s DNA segment that determines resistance) with a DNA test. Presumptive laboratory diagnosis of TRNG is ma susceptibility testing. TRNG infections are usually susce to other effective gonorrhea therapies. Since tetracycli sole therapy for gonorrhea is no longer recommended, should present few problems. However, because approxir 5% of gonorrhea cases in public health clinics and an unk number of cases in the private sector may be treate tetracycline alone, TRNG infections may continue to incre number and spread geographically.

2. Presumptive laboratory diagnosis (no change).

3. Presumptive clinical diagnosis (no change).

E. HIGH-LEVEL PENICILLIN AND TETRACYCLINE RESISTANCE

1. Definitive diagnosis of PPNG/TRNG infection is based on treatment failure with a ß-lactam/tetracycline (e.g. ampicillin/doxycycline) regimen of culture confirmed gonorrhea with a positive ß-lactamase test or high-level resistance to penicillin (zone size ≤ 19 mm). The only definitive laboratory test for TRNG is detection of the tetM determinant (see D.1). PPNG/TRNG infections are usually susceptible to other recommended gonorrhea therapies.

2. Presumptive laboratory diagnosis of PPNG/TRNG is based on presumptive culture diagnosis of gonorrhea (see previous section) and positive ß-lactamase test or high-level resistance to penicillin (zone size ≤ 19 mm) and tetracycline (zone size ≤ 19 mm).

3. Presumptive clinical diagnosis of PPNG/TRNG is reached when a patient presumed to have gonorrhea (see previous section) has a sexual partner with a definitive or presumptive diagnosis of PPNG/TRNG or when a patient is not cured with a ß-lactam/tetracycline therapy and has a positive ß-lactamase test.

III. DISSEMINATED GONOCOCCAL INFECTION (DGI)

A. Definitive diagnosis is identical to uncomplicated gonococcal infections, except that the organism is recovered on culture from the blood, joint fluid, cerebrospinal fluid, or the skin lesions of DGI. Organisms recovered from these sites must be confirmed by carbohydrate utilization, rapid enzyme substrate tests, DNA probe, or serologic (fluorescent antibody or coagglutination) techniques. All gonococcal isolates should be screened for antimicrobial resistance including ß-lactamase testing. Patients in whom DGI is diagnosed should be tested and simultaneously treated for *C. trachomatis* infection.

B. A presumptive diagnosis of DGI applies to patients with definitive or presumptive anogenital gonorrhea or definitive pharyngeal gonorrhea and clinical evidence of dissemination, with a negative culture from the blood, joint fluid, cerebrospinal fluid or the skin lesions of DGI.

SPECIAL SITUATIONS

I. All isolates obtained from the oropharynx, the eyes, or any sites *other* than in the anal or genital regions which are presumptively identified as *N. gonorrhoeae* must be definitively identified. This involves carbohydrate utilization, rapid enzyme substrate tests, DNA probe, fluorescent antibody testing, or coagglutination technique.

II. Confirmatory procedures should be used for specific identification of organisms isolated on selective media from anogenital sites in situations where gonococcal infection appears unlikely and in special social, medicolegal and research situations.

III. Gonorrhea or any other sexually transmitted disease in a prepubertal child should be considered as evidence of sexual abuse until proven otherwise. Because these cases have potentially serious medicolegal consequences, the diagnosis of gonorrhea should be based on an identification of the organism which includes the agreed results of two tests based on different principles (e.g., carbohydrate utilization and rapid enzyme substrate tests, or serologic methods such as fluorescent antibody tests or coagglutination, or DNA probe technique). Such cases, after confirmation, should be reported to appropriate authorities for investigation.

IV. *N. meningitidis*, which occasionally presents in the urethra or rectum of homosexual men, could be confused with *N. gonorrhoeae* if positive presumptive cultures are not confirmed.

V. Gram staining of smears from conjunctiva or skin lesions, or occasionally from joint fluids, may be a helpful adjunct in the diagnosis of gonococcal infections at these sites, but should not replace the culture.

Use of trade names is for identification only and does not constitute endorsement by the Department of Health and Human Services or the Public Health Service.

Hucker's (Modified) Gram Stain for Microorganisms

To prepare a direct smear from a patient, roll swab with patient's specimen on a clean glass slide, making a thin spread; do not smear (leukocytes may be disrupted). Prepare a thin smear from a culture in a drop of water on the slide. Air dry the smear and fix to the glass by rapidly passing the slide through a bunsen burner flame two or three times. The slide should be slightly warm to the skin on the back of the hand.

Staining schedule

1. Stain smears for 1 minute with crystal violet ammonium oxalate.
2. Wash in tap water (not more than 5 seconds).
3. Apply gram's iodine solution for 1 minute.
4. Wash in tap water.
5. Decolorize with 95% ethyl alcohol until washings are no longer blue (about 30 seconds).
   (other decolorizing agents may require less time, e.g., 10 seconds)
6. Wash and shake off excess water.
7. Apply counterstain of safranin for 1 minute.
8. Wash in tap water and blot dry.

Note: some stat laboratories use a rapid or "quick" modification of the gram stain with flooding times decreased to approximately 5 seconds. The decolorization step should continue until colorless solvent flows from the slide. This will usually require 5-10 seconds.

Examination of slide

1. Scan the stained smear with the 110x objective to locate the best area for viewing.
2. Examine the smear microscopically with the oil immersion objective (95-100 x).
3. Gram -positive organisms appear purple and gram -negative organisms appear red.
4. Control slides of representative gram -positive and gram -negative organisms should be examined each time gram stains are performed.

Reagents

Hucker's (modified) crystal violet ammonium oxalate

Stock solution A

crystal violet (90% dye content)	2 g
ethyl alcohol (95%)	20 ml

Stock solution B

ammonium oxalate	0.8 g
distilled water	80.0 ml

For use, prepare a 1:5 dilution of solution a (crystal violet) in distilled water and mix with 4 parts of solution b (ammonium oxalate).

Gram's Iodine Solution

iodine	1.0 g
potassium iodide	2.0 g
distilled water	300 ml

Place the KI in a mortar, add the iodine, and grind with a pestle for 5 to 10 seconds. Add 1 ml of water and grind; add 5 ml of water and grind again; add 10 ml of water and grind. The KI and iodine should now be in solution. Pour into the reagent bottle. Rinse the mortar and pestle with enough water to bring the total volume to 300 ml.

Hucker's counterstain (stock solutions)

safranin 0 (certified)	2.5 g
ethyl alcohol (95 %)	100 ml

To use, add 10 ml of stock solution to 90 ml of distilled water.

Note: if using commercial kits or reagents, follow manufacturer's instructions in the product insert.

SYPHILIS

March 18, 1999

MEMORANDUM

TO: Public Health District Directors
Laboratory Directors
Nurse Managers
Health Counselors

RE: Syphilis Analytical Testing Update

The Microhemagglutination *Treponema pallidium* (MHA-TP) kit is a standard for confirmatory syphilis serological testing. Surprising most laboratories, the company manufacturing the MHA-TP assay recently announced it would discontinue distribution of this product within the United States. The CDC, caught unaware like everyone else, did a quick evaluation of alternative assays. In a letter to State and Territorial Health Department Laboratory Directors dated January 07, 1999, two appropriate alternative assays were identified although neither had obtained FDA standard status. One of the alternatives was a *Treponema pallidium* particle agglutination (TP-PA) assay made by the same company that previously manufactured the MHA-TP assay. The TP-PA differed only in that it used a substitute particle carrier for the antigenic site.

The Division of Consolidated Laboratory Services (DCLS) has also evaluated the performance of the TP-PA assay against existing MHA-TP supplies. Like the CDC, we also demonstrated comparable performance (100%) for both kits when testing routine specimens. We did extend this evaluation by also testing of a set of "problem specimens" (17) obtained from our sample library. These samples had been previously tested as reactive by RPR, positive by Fluorescent Treponemal Antibody Absorption (FTA-ABS) and inconclusive by MHA-TP. All 17 of these specimens were tested as reactive using TP-PA.

Effective March 31, 1999, DCLS will switch from using MHA-TP to TP-PA. New serology forms are being distributed. **Specimen collection, result reporting and interpretation will not change.** Thank you for your patience as we make this change together. If you have any additional questions please call Richard Sexton, the Group Manager for Immunology and Viral Isolation, at (804-786-0592).

Sincerely,

James L. Pearson, Dr. P.H., BCLD
DGS Deputy Director for Consolidated Lab Services

Important Points in the Interpretation of the VDRL

1. More than a reactive VDRL is needed to justify the diagnosis of syphilis.

2. A reactive VDRL in the absence of syphilis is called a Biologic False Positive (BFP). A BFP reaction is proven by exclusion of syphilis.

3. The VDRL is not necessarily reactive in primary syphilis and it usually does not become reactive until at least one week after the appearance of the chancre.

4. If the patient with secondary syphilis develops a very high titer, the VDRL could remain non-reactive due to the prozone phenomenon. The laboratory should therefore be asked to dilute the negative serum and continue the titrition in all cases where suspicious lesions are present.

5. If the patient receives treatment in the later years of his infection, the VDRL may remain positive in low titer or in the high pre-treatment titer ranger for life. In such cases, cure is not based on serologic reversal but on the concept of adequate treatment; that is, treatment which is judged sufficient to protect the patient from the late chronic, crippling, and killing forms of syphilis.

6. A sustained two tube rise in titer (e.g., 1:2 to 1:8) performed by the same laboratory is considered minimal evidence of need for retreatment. The only exception is the adequately treated congenital syphilitic whose titer may fluctuate without any particular significance.

7. When there is any doubt about previous treatment, every pregnant woman with a reactive serologic test for syphilis should be considered to require treatment to ensure the birth of a syphilis free child. The usual medical and epidemiologic follow-up can be performed later to establish the mother's diagnosis.

8. A patient may have late symptomatic syphilis, either acquired or congenital, and have a non-reactive VDRL. A negative non-treponemal test does not rule out syphilis. As in the asymptomatic case, the clinical history, the clinical findings, the antibiotic history, and the results of repeat tests must all be considered in making a diagnosis.

9. A reactive VDRL performed on spinal fluid always represents syphilis unless proved otherwise. Central nervous system involvement is also indicated by elevations of the spinal fluid cell count and total protein. "Burned out" tabes dorsalis may be accompanied by a normal cerebral spinal fluid including a negative CSF VDRL.

Biologic False-Positive Reactions

An acute biologic false-positive (BFP) reaction to tests for syphilis is a reaction of less than six months duration and may be associated with the following conditions:

Bronchitis
Chancroid
Coccidioidomycosis
Diphtheria
Hepatitis
Influenza
Leptospirosis
Lymphogranuloma Venereum
Malaria
Mononucleosis
Pellagra
Pneumonia - Bacterial and Viral
Pregnancy
Ratbite Fever (Sodoku)
Relapsing Fever (Uncommon)
Rhinitis (Common Cold)
Scarlatina
Septicemia
Tinea
Trypanosomiasis (Uncommon)
Tuberculosis
Typhus
Vaccinia
Varicella (Chicken Pox)
Vincent's Angina (Trench Mouth)

A chronic BFP reaction to tests for syphilis is a reaction of more than six months duration. In addition to a treponemal test such as the MHA-TP, additional studies should be considered such as the LE cell test and tests for antinuclear antibodies, rheumatoid factor, and hypergamma-globulinemia. A chronic BFP may be associated with the following:

Addison's Disease
Aging
Atopic Dermatitis
Autoimmune disorder
Bejel (Biologic True Reaction)
Brucellosis
Cirrhosis of Liver
Collagen Disorder
Connective-Tissue disorder
Dermatomyositis
Diabetes Mellitus
Dysproteinemia
Epilepsy
Erythema Nodosa
Glomerulonephritis
Hashimoto's Thyroiditis
Hemolytic Anemia
Histoplasmosis
Idiopathic Thrombocytopenic Purpura
Leprosy
Lupus Erythematosus
Lymphocytic Leukemia
Lymphosarcoma
Major Allergic Conditions
Malaria (Usually Acute BFP)
Metastatic Carcinoma
Multiple Myeloma
Myocardial Infarction
Narcotic addiction (including heroin and methadone)
Pemphigus Vulgaris
Periarteritis Nodosa
Pernicious Anemia
Pinta (Biologic True Reaction)
Rheumatic Fever
Rheumatoid Arthritis
Sarcoidosis
Scleroderma
Subacute Bacterial Endocarditis
Tuberculosis (also Acute BFP)
Yaws (Biologic True Reaction)

THE "FOUR-FOLD" TITER RISE

PRINCIPLES

1. ANTIBODY ASSAYS, ALTHOUGH DONE BY MANY METHODS, ARE EXPRESSED BY A UNIFORM METHOD: THE GREATEST DILUTION OF PATIENT'S SERUM WHICH STILL GIVES A POSITIVE RESULT.

   EXAMPLE: A 1:32 TITER MEANS THAT THE PATIENT'S SERUM CAN BE DILUTED UP TO 32 TIMES AND WILL STILL GIVE A POSITIVE TEST FOR ANTIBODY. THE SAME SERUM DILUTED 64 TIMES OR MORE IS NOT POSITIVE.

2. DILUTIONS ARE ALMOST ALWAYS "TWO-FOLD." THAT IS, EACH DILUTION IS ONE-HALF OF THE CONCENTRATION OF THE PREVIOUS DILUTION.

   EXAMPLE: 1:2 - 1:4 - 1:16 - 1:32.....

3. BY CONVENTION: A FOUR-FOLD TITER RISE BETWEEN 2 SPECIMENS IS NECESSARY FOR SEROLOGIC CONFIRMATION OF INFECTION.

	#1 (acute)	#2 (convalescent)	DX
EXAMPLE: A)	1:16	1:32	Not Confirmed
B)	1:8	1:32	Confirmed

4. A MINIMUM OF 10 DAYS (And preferably 14-21 DAYS) IS NECESSARY BETWEEN ACUTE (#1) AND CONVALESCENT (#2 SPECIMEN), TO ALLOW ENOUGH ANYIBODY PRODUCTION. FIRST BLOOD SHOULD BE DRAWN 24 - 72 HOURS AFTER ONSET OF RASH

HIV/AIDS

Because HIV/AIDS information is continually being revised and updated, the Division of HIV/STD's web site will provides you with links to other sites where you can obtain the most current reports, guidelines, and recommendations regarding HIV/AIDS.

VIRGINIA HIV/STD
INTERVIEW/COUNSELING
TIME PERIODS

DIAGNOSIS	INTERVIEWING/COUNSELING TIME PERIOD
Chlamydia - Symptomatic	60 Days, plus the duration of signs/symptoms
- Asymptpmatic	60 Days
Gonorrhea - Symptomatic	60 Days, plus the duration of signs/symptoms
- Asymptomatic	60 Days
Syphilis - Primary	90 Days, plus duration of signs/symptoms
- Secondary	180 Days, plus duration of signs/symptoms
- Early Latent	365 Days, or less, based upon negative STS, or history of signs/symptoms
HIV - Symptomatic	365 Days or 10 years if married
- Asymptomatic	365 Days or 10 years if married
AIDS	365 Days + or 10 years if married

HIV Counseling, Testing, and Partner Counseling and Referral Services

A. Counseling and Testing

Counseling provides a critical opportunity to assist the client in identifying his or her risk of acquiring or transmitting HIV. Counseling also provides an opportunity to negotiate and reinforce a plan to reduce or eliminate the risk. Counseling prior to HIV testing, (test decision counseling) should prepare the client to receive and manage his or her test result. This counseling should also: 1) facilitate an accurate perception of HIV risk for those who are unaware, uninformed, misinformed, or in denial; 2) translate the client's risk perception into a risk reduction plan that may be enhanced by knowledge of HIV infection status; and 3) support the client in behavior changes that they have already made: and assist them in sustaining behavior changes that reduce their risk acquiring or transmitting HIV. Clients should be offered reasonable opportunities to receive HIV antibody counseling and testing services anonymously. Anonymous counseling and testing may encourage some persons at risk to seek services who would otherwise be reluctant to do so.

Providing HIV antibody test results to a client involves interpretation that is based on the test result and the person's specific risk for HIV infection and dealing with the client's reaction to his/her test result. The client will most often focus on the result itself. Client-centered counseling is required to reassess behavioral risk that my influence the interpretation. When the client receives HIV test results, the primary public health purposes of counseling are: 1) to reinforce perception of risk for those who are unaware or uninformed; 2) to help uninfected persons initiate and sustain behavior changes that reduce their risk of becoming infected; 3) to arrange access to necessary medical prevention, and case management services as needed; 4) to assist those who may be infected to avoid infecting others and remain healthy; 5) to support and/or assist infected clients to ensure the referral of as many sex or needle sharing partners as possible; and 6) help partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

The risk assessment and risk reduction plan developed during counseling prior to HIV testing provide a framework for strenghthening efforts the client has already taken toward healthier behaviors and for recommending modifications based upon the HIV test result.

B. Partner Counseling and Referral Services

House Bill 1974 enacted by the 1989 General Assembly mandated the reporting of all HIV antibody positive test results effective July 1, 1989. The bill also allowed the Board of Health to adopt regulations for the implementation of Partner Counseling and Referral Services (PCRS) (formerly known as Partner Notification and/or contact tracing). Accordingly, the Board amended the Regulations for Disease Reporting and Control to incorporate the following effective March 28, 1990.

"When notified about a disease specified in Section 3.1A of the regulations, the local health department shall perform contact tracing for infectious syphilis and HIV infection, and may perform contact tracing for other diseases if deemed necessary to protect the public health. The local health director shall have the responsibility to accomplish contact tracing by either having patients inform their contacts directly or through obtaining pertinent information such as names, descriptions, and addresses to enable the health department staff to inform the contacts. All contacts of HIV infection shall be afforded the opportunity for individual face-to-face disclosure to contacts by the health department. All information obtained shall be kept stricIty confidential."

It is the Department's policy PCRS for HIV infection be limited to:

1. The sexual and needle-sharing partners named by HIV infected patients.

2. Virginia residents who are the sexual and/or needle-sharing partners of HIV infected residents of other states, when so notified by the Division of HIV/STD.

3. Those persons included in house Bill 1974 - 32.1-36 (includes federal law for 10 years to inform spouses)

PCRS should not not be initiated on hearsay.

When HIV infected persons and their sexual and/or needle-sharing partners are out-of-state residents, the Division of HIV/STD should be notified. The Division will transmit the information to the appropriate State Health Department.

Sexually Transmitted Disease Epidemiology

Introduction

A program for the control and prevention of STDs can be separated into the identification and treatment of persons who are infected, and the prevention of transmission of disease from the infected person to the non-infected.

Identification of infected persons is accomplished by setting up a community-wide STD Control Program.

There are four aspects to such a Program:

1. Diagnosis and Treatment

    a. Clinic facilities and laboratory services for the diagnosis and treatment of STD maintained in each health district, offering convenient and high quality medical care.

    b. Participation by private physicians in running these clinics is critical for the control program to function effectively.

2. Screening (Surveillance)

    a. The current blood testing program for the identification of syphilis is productive and efficient. More than 24,000 active tests for syphilis are reported each year, and half the new cases are identified through this activity.

    b. The gonorrhea culture screening program has been very successful. Approximately 200,000 females are tested annually, with almost 12,000 new cases identified.

3. Education

    a. The public must be informed or the existence of STD, the recognition of the signs/symptoms of STD and the need for immediate medical care.

    b. The private medical community must be encouraged to actively support the educational activities of the control program.

4. Epidemiology

Specialized services beyond merely the adequate treatment of persons who are infected is necessary if the spread of STD is to be contained. That part of the STD control effort that most distinguishes it from the more traditional epidemiologic approach to disease control is its preoccupation with the individual patient.

The STD Contact Interview

The prime goal of the contact interview is to elicit from the patient the names of sex contacts, and information that will enable the health care worker to rapidly locate these persons. Most patients are prepared to present unique obstacles to prevent the interviewer from reaching this goal. The STD contact/interview format is planned and organized but allows the flexibility needed to analyze and solve the patient's problems.

A fundamental "pre-interview" analysis is required before the interview to assess "problem areas" and the medical history. to identify potential "problem areas," the patient's name and address and any other descriptive information should be verified. Situations that are particularly threatened when associated with STD are often the basis for interviewing problems, e.g., young persons living with their parents or married persons with their own problems. Early recognition of potential "problem area" will help the interviewer be prepared with solutions.

Too often the interviewer is tempted to label as hostile a patient who does not freely name contacts. What must be recognized is that the patient has what he considers to be valid reasons for not confiding in the interviewer. The best way to deal with this kind of patient is to attempt to find out what the reasons are and solve the patient's problem to his satisfaction.

The patient who presents the interviewer with any of the familiar stories. such as having been drunk and unable to remember his contacts, or having had sex only with unknown pick-ups, is usually telling the interviewer that he does not feel that he can tell the truth. Three steps are necessary to deal with such patients:

1. Analysis

The interviewer should try to decide the root cause of the problem. Often the patient thinks he knows who gave him the disease, has decided not to see that person again, and sees no reason to talk about anyone else. Also, the patient may not really understand the confidential nature of the epidemiologic process. He does not know who will have access to the information he provides nor how the information will be used. Occasionally the patient feels competent to handle his own follow-up and would prefer that the interviewer

not be involved. The interviewer must try to figure out this patient's problem, whatever it might be.

2. Confrontation

It is critical that the patient recognize that the interviewer is interested only in the names of persons known by the patient, who may have been exposed to STD, and who must have an opportunity to seek medical treatment. If the interviewer does not immediately reject any response he considers to be untrue, the patient will not recant; this may result in more truthful responses.

The medical history must be carefully analyzed. Patients with histories of past STD often are familiar with the epidemiologic process and may be expected to have less anxiety about infection or the interview. A good interviewer will be prepared to cope with the "steady customer." Regardless of the number of previous infections, the interviewer must prepare a detailed analysis of the stage and possible duration of the patient's current infection.

The patient who is apparently cooperative will give the interviewer the names of one or more recent sex partners. Most patients will tend to name those persons who they believe were responsible for infecting them, usually one-time or occasional contacts. When the patient stops giving names, the interviewer should try for additional contacts and specifically take the initiative in asking for the name of a steady sex contact since the patient is often reluctant to accept the idea that this person could possibly be infected.

In asking for names, the interviewer must not assume that the patient is heterosexual. All references to contacts should be gender-neutral. It is better to say "Who is another person you have had sex with," rather than speak about "women and girls." If patient gives only female contacts, the interviewer must suggest that the men and boys with whom the patients has had sex should also have an opportunity to see a doctor. Often, this suggestion to either a male or female will motivate the patient to admit to same-sex contacts. If the attempt to elicit contacts of the same sex is not made, the interviewer may be doing only "half the job."

Most patients will not speak candidly about sex partners without being given a good reason for yielding this sensitive information; therefore, the interviewer must be prepared to motivate the patient.

3. Motivation

Motivate the patient with logical reasons why it is important to yield the names of contacts. Most of these reasons are routine and directed to the

patient's concern for his own well-being:

a. Spread and Reinfection. The concept that the patient will be re-exposed to sex partners and reinfected is a real risk. Furthermore, the patient's infected contacts will continue to spread the disease and the probability of reinfection from these second-generation contacts is great.

b. Asymptomatic Infection. The patients has already been told that one can have STD without symptoms. He can be told that he may not know if he has been reinfected.

c. Congenital Infection. The possibility of the spread of STD to unborn children should be mentioned.

d. Prophylactic Treatment. Since the patients is aware of the specific incubation period(s), it can be explained that if his contacts are located quickly enough, they can be given prophylactic treatment and will not develop the disease.

e. Urgency. For the patient who fears exposure and possible retribution from his contacts, the idea that if he cooperates fully he can be protected is sometimes effective. The interviewer can explain that if the patients is not candid about his sex partners, that, as those contacts develop STD, are treated and are interviewed, his name will be mentioned repeatedly. Each time he will have to be notified and re-examined. The patient can avoid this if all his contacts are examined immediately.

The patient may offer a negative response or pose a problem at any time during the contact elicitation session. The interviewer's response should include a motivation that counteracts the possible reasons why the patient is not cooperating. Frequently, the cause of patients' problems is at least in part fear of being identified as the informant. If the interviewer will devote a few minutes discussing with the patient exactly how he plans to conduct the field follow-up of contacts, he will often win the patient's confidence. Merely telling the patient that the interview is confidential is not enough. There must be a detailed explanation of the ways in which the interviewer will protect the patients and his contacts.

Problems related to confidentiality and misunderstanding of the interviewer's role should be expected to occur. They can be overcome with experience, logic, and simple common sense.

Through a series of questions about the dates of first and last exposure and the frequency of exposure, "an epidemiologic relationship' between the patient and his contacts is developed. For each contact, the interviewer will ask for the dates of the most recent exposure and the first exposure. Finally, he asks how often the patient had sex with each person names. There are two reasons for this. First, to be certain to identify the sex partner(s) of long-standing. Second, the persons names are likely to be either the source or spread. If analysis of the exposure history shows no steady contact or no source-period contact, confrontation and motivation must be continued.

When the interviewer is satisfied that the patient has named all of his contacts, he should concentrate on obtaining locating information on each contact. The patient may indicate a desire to notify his contacts. This arrangement is satisfactory, but the patient should be made aware of the dangers inherent in this decision. Even if the patient is going to speak to his contacts, the interviewer must obtain locating information so that the examining physician will know to what the contacts have been exposed and the kind of examination that is necessary.

The locating information must include as many of the following items as possible:

1. Home and/or work address
2. Telephone numbers
3. Physical description
    a. Age
    b. Race
    c. Sex
    d. Weight
    e. Height
    f. Hair color & style
    g. Other distinguishing features.
4. Marital Status
5. Places the contact is known to frequent
6. Names and addresses of friends
7. Any other information.

Maps and telephone directories should be used to insure that the locating information is correct.

STD Investigative Activities

General Information

After the patient interview/counseling session has been completed, it is the responsibility of the health care worker to initiate immediate follow-up on all persons whom the worker feels should receive an examination. It is up to the discretion of the worker as to what is a minimal amount of information with which the contact can be found. The examination of all these persons must proceed with all possible speed. Every year numerous cases of STD occur as a result of either delay or failure in the investigative process. The faster these individuals are followed up, the greater the opportunity to prevent cases.

It is of utmost importance that the STD worker create an atmosphere in the follow-up process which will not damage the relationship among public health agencies, private physicians, and the general public. Many people are very impressionable and one or two negative experiences with representatives of health departments can do a great deal of harm to the STD control effort. In the investigation, the workers should always exercise discretion and diplomacy so as not to cause embarrassment to the health department or the person being investigated.

The medical and epidemiologic facts gathered during the investigation are confidential; therefore, the identities of the informants cannot be revealed. Because the STD worker is an official representative of a health care agency and is entrusted with extremely confidential information, it is extremely important that the investigation be tempered with understanding, tact, tolerance, and good sound judgment. With a limited number of facts which can only be discussed with suspected persons in a guarded and restricted manner, the worker must be very persuasive if he is to successfully induce suspected individuals to present themselves for examination.

Upon receiving or preparing a form for investigation, the worker should first check the local health department or clinic files to establish whether or not the person to be investigated has a previous record, either medical or epidemiologic. Many times a field investigation could be eliminated if the proper records are available. The person in question may have received a very recent examination for the disease suspected or have been treated for the disease since the alleged date of last exposure. Thus, a final disposition can be made immediately and no investigation would be necessary.

It is often possible to bring a person to examination by telephone or letter, but in most instances a personal visit is the best and most confidential way of referring persons for an examination. Through experience the worker will learn that each investigation must be made with complete self-assurance and that the art of motivating patients to examination is a very important one.

Field Sources of Information

The public health worker must become very knowledgeable about the locality in which he serves. The worker will ma ny times find it necessary to talk to many people about persons he is required to investigate. However, in soliciting information it is always important to approach with tact and caution so as to avoid causing any embarrassment. Certainly, the worker will never reveal the exact nature of his interest in any specific individual.

The following have been found to contribute a great deal of assistance in epidemiologic investigations:

1. Health department records, including cross reference directories, syphilis records, gonorrhea interview records, investigative records, morbidity files, and regular patient files.

2. City and county records can be helpful also. Personnel office, marriage license bureau, voter registration, motor vehicle registration, public utilities, libraries and welfare records are other examples.

3. Law enforcement agencies, correctional institutions, and training centers can many times lend assistance. These include city and county jails, probation offices, juvenile detention centers, Job Corps Training Centers, parole offices and many others. Police and sheriffs' files and their knowledge of the whereabouts of certain individuals should be used as a last resort and in such a manner that the investigator will never be identified with these law enforcement groups.

4. Post Office information can be an invaluable source in some instances. In order to ascertain an individual's forwarding address, or to get information on post office boxes, consult the local post office in the area where the individual lives or last lived.

5. It is also important to know the places where people gather to spend leisure and socialization time. It is advisable to become friends of the owners, managers, waitresses, bartenders, etc., of certain establishments. These people can provide much helpful information if proper relationships have been established.

This is obviously not a complete list, but only possible areas to explore in difficult investigations. It is important that sources of information be made available to co-workers for their benefit.

Principles of Investigation

In concluding this section, certain investigative principles should be pointed out and others re-emphasized. These are as follows:

1. Carefully analyze contact exposure information. Determine priorities on the basis of an analytical appraisal of all available medical and epidemiologic data and with particular emphasis upon the prevention of new cases.

2. Never reveal the name of an informant.

3. Never tell a contact or any other suspected person that they have a disease.

4. Arrange field work on the basis of priority. The initial examination of all contacts should preferably be completed before the first re-interview. By so doing, the re-interview is performed with a knowledge of whether the patient's source of infection has been found and/or other "spread infections" have been identified. This information gives an indication of how to pursue the epidemiologic search. Further locating information nay also need to be obtained about contacts and suspects obtained in the initial interview.

5. Be a good listener and a diplomatic inquisitor. Gossiping, name dropping, and loose talk can reduce effectiveness, cause embarrassment to oneself and others, produce law suits, and ruin control programs. The job of the health care worker is to prevent disease transmission and its complications.

6. The health care worker is not a messenger boy. He should make every effort to see the suspected individual personally. However, occasionally it becomes necessary to leave with a friend, or relative, an appointment form for a person to report for examination. The appointment form should not contain words such as "sexually transmitted disease," "syphilis," "gonorrhea," or "contact," etc. The message should infer importance, state the time, day, and place (not STD Clinic) to report. The form should be placed in a plain sealed envelope on which the suspected person's name is written and may be marked as personal.

7. Epidemiologic investigations must not be allowed to create marital discord or result in parental chastisement of children. Regardless of the degree of difficulty, the worker must provide every person with "status protection."

8. Medical and/or epidemiologic records are confidential. If records are taken into the field, they should be carried in such a way to insure against being lost, and of course should never be shown or displayed.

The Format for Sexually Transmitted Diseases Interviewing/Counseling

(The Comprehensive Disease Intervention Approach)

I. INTRODUCTION, PROFESSIONAL ROLES AND PURPOSE

A. Introduce yourself (and anyone else present) to the patient.
B. Explain your role as a trained health care professional.
C. Explain that all work is performed in the strictest confidence and that problems will be minimized for everyone involved.
D. Define the purpose of the session:

1. To manage this infection (medical compliance).
2. To prevent future infections (examine/treat sex partners and behaviors to reduce risk).
3. To know what to do if re-exposed to disease.

II. PATIENT ASSESSMENT

Establish rapport and identify potential "problem areas" through a discussion of the following:

A. Patient Concerns

1. Identify any patient concerns, e.g., disease treatment, cure, sex partners, confidentiality, time, clinic experience, etc.
2. Resolve concerns even if it means moving to other sections of the format, e.g., sex partners.
3. Continue to assess the patient's communication skills and develop potential approaches to any "problem areas" anticipated.
4. Determine the content and emphasis of disease intervention behaviors based on patient attitudes and needs.
5. Determine who or what motivated the patient to get examined (if not by field referral).

B. Socio-sexual Information

1. Describe the importance of having accurate personal and medical information in resolving the patient's disease.

2. Determine the extent of rapport developed in the interaction to this point by carefully observing the patient during the following section.

3. Pursue the following items of information assessing patient responses and using two-way communication:

   a. Address and phone number (current and recent past, including apartment number).
   b. Emergency locating information.
   c. "Living-with"/marital status.
   d. Employment information.
   e. Lifestyle (travel, recreational behaviors, social groups).

NOTE: Sensitivity to the preceding questions is second only to details about sexual partners. Most patients will respond positively and answer openly; however, be prepared to begin problem-solving and provide a reassuring answer if the patients asks, "Why do you need that information?" This type of response, along with nonverbal signs of discomfort, are indicators of patient concerns. This section will allow the interviewer to confirm the degree of rapport and to resolve any previously unexpressed patient concerns. Resolving these potential problems will eliminate obstacles in later sections. Restate the purpose of the session and firmly reinforce confidentiality and professional role. If appropriate explanations do not remove the patient's hesitation, continue problem-solving to resolve concerns which are commanding the person's attention before proceeding with the session.

C. <u>Medical History and Disease Comprehension</u>

1. Determine what the patient knows about the disease.
2. Reinforce what the patient knows about the disease and correct any misconceptions that are presented.
3. Present as an individualized discussion, <u>not</u> a medical lecture.
4. Discuss the following points:

   a. The <u>basic</u> natural course of the disease and modes of transmission.
   b. The patient's STD history or previous tests for STD.
   c. The patient's symptom history.

III. **DISEASE INTERVENTION BEHAVIORS** (order based on patient needs assessment)

A. Take Medication (when applicable)

1. Emphasize need for taking all the medication.
2. Establish a specific medication schedule.
3. Discuss contraindications and potential side effects.
4. Identify and discuss potential compliance problems.

B. Return for Follow-up Tests (when applicable.

1. Review medical purpose of retests.
2. Negotiate appointment date and time.
3. Emphasize need to avoid "unprotected sex" until retest is negative.
4. Identify and discuss potential compliance problems.

C. Assure the Examination of all Sex Partners (for all patients)

1. Introduction of the process and its importance

a. Review confidentiality and the professional role of the health care worker.
b. Briefly review the patient's comprehension of the disease and the modes of disease transmission.
c. Define the significance of immediate sex partner examination and treatment, emphasizing that one or more may have an STD (either the same as the patient or another undiagnosed infection) which continues to place the patient's health in jeopardy.
d. Establish that sex partner referral will be done immediately and will occur for everyone's benefit.

2. Sex Partner Identification and Discussion

a. Assess the response to the session thus far and determine the patient's concerns regarding sex partners.
b. Determine the patient's capability to participate in sex partner referral.
c. Select the approach which is most likely to assure the patient will identify and discuss sex partners at this point. This can be approached in one of two ways: 1) The patient either is asked to provide the names of sex partners ("Name First") or 2) for a decision on how he plans to assure these people are examined ("Decision First"). The approach chosen is that which is judged

most likely to evoke a positive and productive response from the particular patient. The "Decision First" approach is for use in situations where prior patient reactions (e.g., apathy, edginess, cynicism, etc.) portend a confrontation will occur when he is asked for the names of sexual partners. Such a confrontation using the "Name First" approach may pose serious and time-consuming problems for the interviewer, especially if the patient anticipates the agenda and is prepared with a "story" (e.g. "prostitutes," "pickups," "anonymous bathhouse," etc.). The "Decision First" approach does not necessarily avert the confrontation, but it can derail a patient's plans to evade the issue. By having the patient make a non-threatening decision first, the interviewer has him acknowledge two important facts: 1) the sexual partner is someone who is known, and 2) the person is known well enough to refer. Even in the face of patient resistance, these acknowledgments will significantly improve the ability of the interviewer to solve the problems.

"NAME FIRST"

* <u>Identify sex partners before discussing possible referral methods for them</u>

A. Ask for the name of the last or steady sex partner.
B. Determine the exposure history for that sex partner.
C. Proceed to identify all other sex partners and determine exposure information for each in the same manner.
D. Analyze and assess responses for conflicting information.
E. Identify problems indicated by:

1. "An exposure gap" especially when symptoms were present.
2. Lack of disease source or source candidate.
3. Lifestyle conflicts with presented information.

F. Confront inconsistencies and clarify problems.
G. Evaluate problem and select appropriate solution(s). Reinforcement of confidentiality and professionalism is important. More specific motivation approached to problem solving are:

1. Prevention of Reinfection

   a. possible spread of the disease and increased risk of reinfection.
   b. potential of having asymptomatic sex partners.
   c. risk of being asymptomatic if reinfected.
   d. risk of complications if reinfected.
   e. inconvenience.

2. Concern about Sex Partners

   a. rapid treatment reduces spread potential and chances of complications.
   b. avoid their resentment and possible reprisals later at being selfishly denied help now.

(H) Gather the following information about each sex partner:

1. Names(s) (including nicknames)
2. Address (including apartment number(s)
3. Telephone number(s)
4. "Living/with" status
5. Employer and work telephone number(s)
6. Age/race/sex/marital status
7. Physical description
8. Other locating information.

(I) Determine methods for sex partner referral for each sex partner:

1. For a Health Department Referral, the interviewer assumes full responsibility for the referral and assures that:

   a. Patient anonymity is protected.
   b. Sex partner's right to confidentiality is established.
   c. Plan for the referral is established, including best time, place, and

method to use in approaching the sex partner, and possible problems surrounding the referral.

2. For a Contact Referral, a negotiated agreement between the patient and the interviewer is established that outlines who will make the initial referral attempt. The agreement assures that:

   a. Sex partners to be referred by the interviewer are managed according to the guidelines for the health department referral method.

   b. Sex partners to be referred by the patient are managed according to specific guidelines which define the:

      i. Role of the patient.
      ii. Role of the interviewer.
      iii. When/how the referral will be done.
      iv. Where the sex partner will be referred.
      v. What the patient will say to the sex partner.

"DECISION FIRST"

* Discuss referral options for each sex partner before identifying them.

A. Describe the two methods of sex partner referral.
B. Ask for a decision on the referral method to be used with the last or steady sex partner.
C. Ask for the name of that sex partner.
D. Determine the exposure history for that sex partner.
E. Proceed to identify all other sex partners and determine exposure information for each in the same manner.
F. Analyze and assess patient responses for conflicts in information.

G. Identify problems indicated by:

1. "An exposure gap" especially when symptoms were present.
2. Lack of disease source or source candidate.
3. Lifestyle conflicts with presented information.

H. Confront inconsistencies and clarify problems.

I. Evaluate problem and select appropriate solution(s). Reinforcement of confidentiality and professionalism is important. More specific motivational approaches to problem solving have already been mentioned on page _____

J. Determine method of sex partner referral for each sex partner as described previously.

K. Gather the baseline information (name, address, etc.) about each sex partner as previously indicated.

D. Reduce Risk (for all patients)

1. Discuss patient's sexual lifestyle, if not previously doe.
2. Present options tailored to the patient's sexual lifestyle.
3. Emphasize avoiding exposure:

   a. until retest is negative.
   b. until all sex partners are treated.
   c. unless condoms are used.
   d. when symptoms are present or disease is suspected in sex partners.

E. Respond to Disease Suspicion (for all patients)

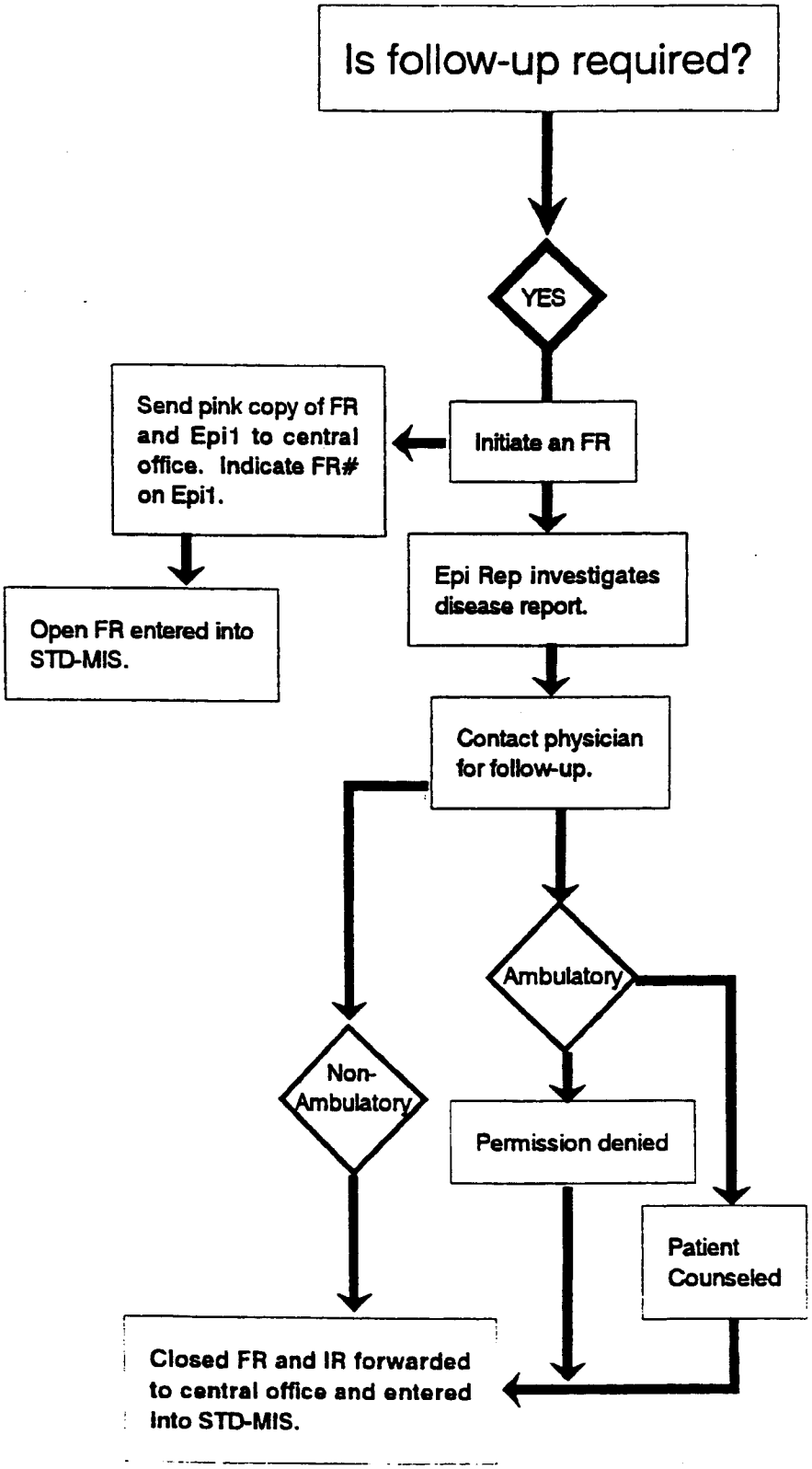
1. Review the patient's clinical symptoms and those of other common STDs.
2. Counsel the patient to respond to disease suspicion by:

   a. immediately visiting the clinic.
   b. avoiding all sex when disease is suspected.
   c. bringing sex partner(s) to examination, or by bringing locating information about them.

IV. CONCLUSION

A. Evaluate remaining patient needs or potential compliance problems.
B. Review and reinforce all components of the compliance plan.
C. Redefine respective roles and procedures in the referral of each sex partner.
D. Reinforce commitments to communicate information, e.g., "marginally locatable" sex partners, referral difficulties, test results, etc., and make arrangements for a re-interview, if necessary.
E. Analyze case information for any inconsistencies, gaps, or mission information.
F. Confront any inconsistencies and/or apply problem-solving approaches to resolve problems.

AIDS EPIDEMIOLOGY
FIELD CRITERIA FOR FOLLOW-UP



Interview: Face-to-face contact with patient by public health personnel to provide posttest counseling, partner notification, referral to medical/social services and to establish transmission mode.

Sexually Transmitted Disease Control Records and Reports

	STD Record	Purpose	Retention Period	Retention Agency
1.	STD Health History and Physical Exam (CHS-10)	Record clinical, laboratory and epidemiological information on patients infected with, exposed to, or suspected of having an STD.	10 years	Local Health Department
2.	Office of Epi Confidential Morbidity Report (Epi 1)	Report person diagnosed with STD/HIV .	10 years	Bureau of STD/AIDS Central Registry Unit
3.	Gonorrhea Culture Report (DGS-22-065)	Provide laboratory culture results on persons tested for gonorrhea	10 years	Local Health Department
4.	Serologic Test for HIV-1 Antibody	Record demographics and epidemiologic information on persons tested for HIV antibody	10 years	Local Health Department
5.	Bureau of Microbiology Chlamydia Report Form (DGS-22-065)	Provide laboratory results on persons tested for chlamydia	10 years	Local Health Department
6.	STD Field Record (CDC 73-2936S)	Provide locating and identifying information on STD contacts/suspects	5 years	Local Health Department
7.	Interview Record (CDC 73-54)	Record STD/HIV interview information and the results of investigative/field activity	5 years	Local Health Department

The number of this section was assigned by the Virginia Code Commission, the 1970 act having assigned no number.

CHAPTER 7.

VIRGINIA PUBLIC RECORDS ACT.

§ 42.1-76. Legislative intent; title of chapter. — The General Assembly intends by this chapter to establish a single body of law applicable to all public officers and employees on the subject of public records management and preservation and to ensure that the procedures used to manage and preserve public records will be uniform throughout the Commonwealth.

This chapter may be cited as the Virginia Public Records Act. (1976, c. 746.)

Law Review. — For survey of Virginia law on evidence for the year 1978-1979, see 66 Va. L. Rev. 293 (1980).

§ 42.1-77. Definitions. — As used in this chapter:

"Agency" means all boards, commissions, departments, divisions, institutions, authorities, or parts thereof, of the Commonwealth or its political subdivisions and includes the offices of constitutional officers.

"Archival quality" means a quality of reproduction consistent with established standards specified by state and national agencies and organizations responsible for establishing such standards, such as the Association for Information and Image Management, the American Standards Association, and the National Bureau of Standards.

"Board" means the State Library Board.

"Council" means the State Public Records Advisory Council.

"Custodian" means the public official in charge of an office having public records.

"State Librarian" means the State Librarian or his designated representative.

"Public official" means all persons holding any office created by the Constitution of Virginia or by any act of the General Assembly, the Governor and all other officers of the executive branch of the state government, and all other officers, heads, presidents or chairmen of boards, commissions, departments, and agencies of the state government or its political subdivisions.

"Public records" means, but is not limited to, all written books, papers, letters, documents, photographs, tapes, microfiche, microfilm, photostats, sound recordings, maps, other documentary materials or information in any recording medium regardless of physical form or characteristics, including electronically recorded data, made or received in pursuance of law or in connection with the transaction of public business by any agency or employee of state government or its political subdivisions.

Nonrecord materials, meaning reference books and exhibit materials made or acquired and preserved solely for reference use or exhibition purposes, extra copies of documents preserved only for convenience or reference, and stocks of publications, shall not be included within the definition of public records as used in this chapter.

"Archival records" means all noncurrent records of continuing and enduring value useful to the citizens of the Commonwealth and necessary to the administrative functions of public agencies in the conduct of services and activities mandated by law. In appraisal of public records deemed archival, the terms "administrative," "legal," "fiscal," and "historical" shall be defined as:

1. *"Administrative value"*: Records shall be deemed of administrative value if they have continuing utility in the operation of an agency.

2. *"Legal value"*: Records shall be deemed of legal value when they document actions taken in the protection and proving of legal or civil rights and obligations of individuals and agencies.

3. *"Fiscal value"*: Records shall be deemed of fiscal value so long as they are needed to document and verify financial authorizations, obligations and transactions.

4. *"Historical value"*: Records shall be deemed of historical value when they contain unique information, regardless of age, which provides understanding of some aspect of the government and promotes the development of an informed and enlightened citizenry.

"Medical records" means the documentation of health care services, whether physical or mental, rendered by direct or indirect patient-provider interaction which is used as a mechanism for tracking the patient's health care status.

"Persons under a disability" means persons so defined under subsection A of § 8.01-229. (1976, c. 746; 1977, c. 501; 1981, c. 637; 1987, c. 217; 1990, c. 778.)

The 1990 amendment, in the paragraph defining "Archival quality," substituted "with established standards" for "with reproduction standards," "state and national agencies and organizations responsible for establishing such standards, such as the Association for Information and Image Management, the" for "the National Micrographics Association," and "and the National Bureau of Standards" for "or National Bureau of Standards"; substituted "Council" for "Committee" in the paragraph defining "Council"; in the paragraph defining "Public records," inserted "but is not limited to," substituted "including electronically recorded data" for "including data processing devices and computers," inserted "or employee," and deleted "the" preceding "state government", and in the paragraph defining "Archival records" in the first sentence, inserted "all noncurrent," deleted "those" preceding "services and activities", and inserted "continuing" in subdivision 1.

§ 42.1-78. Confidentiality safeguarded. — Any records made confidential by law shall be so treated. Records which by law are required to be closed to the public shall not be deemed to be made open to the public under the provisions of this chapter. Records in the custody of the State Library and Archives which are required to be closed to the public shall be open for public access 100 years after the date of creation of the record. No provision of this chapter shall be construed to authorize or require the opening of any records ordered to be sealed by a court. All records deposited in the archives that are not made confidential by law shall be open to public access. (1976, c. 746; 1979, c. 110; 1990, c. 778.)

The 1990 amendment divided the former second sentence into the present second and fourth sentences, deleted "and" at the end of the present second sentence, added the third sentence, and added the last sentence.

§ 42.1-79. Records management function vested in Board; State Library Board to be official custodian; State Archivist. — The archival and records management function shall be vested in the State Library Board. The State Library Board shall be the official custodian and trustee for the Commonwealth of all public records of whatever kind which are transferred to it from any public office of the Commonwealth or any political subdivision thereof. As the Commonwealth's official repository of public records, the State Library and Archives shall assume administrative control of such records on behalf of the Commonwealth.

The State Librarian shall name a State Archivist who shall perform such functions as the State Librarian assigns. (1976, c. 746; 1986, c. 565; 1990, c. 778.)

The 1990 amendment added the last sentence in the first paragraph.

§ 42.1-79.1. Retention and disposition of medical records. — The medical records of all persons not under a disability shall be retained by all public agencies acting as custodians of medical records for ten years following the last date of treatment or contact. Such agencies shall retain the medical records of minors and persons under a disability for a minimum of five years following the age of majority or the removal of the disability, or ten years following the last date of treatment or contact, whichever comes later. Such agencies shall retain the medical records of deceased persons for a minimum of five years following the date of death.

Agencies of the Commonwealth which generate medical records shall be encouraged to destroy such medical records upon expiration of the required retention period. Such agencies may, at their discretion, retain summaries of destroyed medical records.

Medical records submitted to the State Library and Archives for retention and disposition in accordance with the terms of this section are presumed to be inactive. It shall be the duty of the originating agency to (i) designate medical records of minors, persons under a disability, or deceased persons prior to submission to the State Library and Archives for retention and disposition, and (ii) to notify patients that their records will be destroyed after the appropriate retention period. Unless notified otherwise by the originating agency, the State Librarian shall begin to count the required retention period from the first date of submission. Prior to destroying any medical records, the State Librarian or his designee shall notify the originating agency that the retention period has run out and that, unless the agency reclaims the medical records, the records will be destroyed.

No employee of the State Library and Archives or any agency acting in accordance with the terms of this section shall be liable, civilly or criminally, for the destruction of medical records.

The provisions of this section shall not supersede the provisions of § 16.1-306 or any other laws of this Commonwealth pertaining to the retention and disposition of records generated by agencies other than those agencies originating medical records. (1987, c. 217.)

§ 42.1-80. State Public Records Advisory Council continued; members; chairman and vice-chairman; compensation. — The State Public Records Advisory Council is continued. The Advisory Council shall consist of eleven members. The Advisory Council membership shall include the Secretary of the Commonwealth, the State Librarian, the Attorney General, the State Health Commissioner, the Commonwealth Transportation Commissioner, the Director of the Department of Information Technology, the Auditor of Public Accounts, the Executive Secretary of the Supreme Court, or their designated representatives and three members to be appointed by the Governor from the Commonwealth at large. The gubernatorial appointments shall include two clerks of courts of record and a member of a local governing body. Those members appointed by the Governor shall remain members of the Advisory Council for a term coincident with that of the Governor making the appointment, or until their successors are appointed and qualified. The Advisory Council shall elect annually from its membership a chairman and vice-chairman. Members of the Advisory Council shall receive no compensation for their services but shall be paid their reasonable and necessary expenses incurred in the performance of their duties. (1976, c. 746; 1977, c. 501; 1984, c. 720; 1985, c. 448; 1990, c. 778.)

The 1990 amendment, in the first sentence, substituted "State Public Records Advisory Council" for "State Public Records Advisory Committee," and deleted "and shall hereafter be known as the State Public Records Advisory Council" following "is continued," substituted "eleven members" for "ten members" in the second sentence, in the third sentence, inserted "the Attorney General," and substituted "the Commonwealth Transportation Commissioner" for "the State Highway and Transportation Commissioner," and substituted "successors are appointed" for "successors shall be appointed" in the fifth sentence.

§ 42.1-81. Powers and responsibilities of Council. — The Council shall propose to the State Library Board rules, regulations, and standards, not inconsistent with law, for the purpose of establishing uniform guidelines for the management and preservation of public records throughout the Commonwealth. The Council shall have the power to appoint such subcommittees and advisory bodies as it deems advisable. The Council shall be assisted in the execution of its responsibilities by the State Librarian. (1976, c. 746; 1990, c. 778.)

The 1990 amendment, in the first sentence, substituted "Council" for "Committee," substituted "shall propose to the State Library Board" for "shall have responsibility for proposing to the State Library Board," and substituted "Commonwealth" for "State," and substituted "Council" for "Committee" in the second and third sentences.

§ 42.1-82. Duties and powers of Library Board. — The State Library Board shall with the advice of the Council:

1. Issue regulations to facilitate the creation, preservation, storage, filing, microfilming, management, and destruction of public records by all agencies. Such regulations shall establish procedures for records management containing recommendations for the retention, disposal or other disposition of public

records; procedures for the physical destruction or other disposition of public records proposed for disposal; and standards for the reproduction of records by photocopy or microphotography processes with the view to the disposal of the original records. Such standards shall relate to the quality of film used, preparation of the records for filming, proper identification of the records so that any individual document or series of documents can be located on the film with reasonable facility, and that the copies contain all significant record detail, to the end that the photographic or microphotographic copies shall be of archival quality.

2. Issue regulations specifying permissible qualities of paper, ink, and other materials to be used by agencies for public record purposes. The Board shall determine the specifications for and shall select and make available to all agencies lists of approved papers, photographic materials, ink, typewriter ribbons, carbon papers, stamping pads, or other writing devices for different classes of public records, and only those approved may be purchased for use in the making of such records. These regulations and specifications shall apply to clerks of courts of record.

3. Provide assistance to agencies in determining what records no longer have administrative, legal, fiscal, or historical value and should be destroyed or disposed of in another manner. Each public official having in his custody official records shall assist the Board in the preparation of an inventory of all public records in his custody and in preparing a suggested schedule for retention and disposition of such records. No land or personal property book shall be destroyed without being first offered to the State Library and Archives for preservation.

All records created prior to the Constitution of 1902 that are declared archival may be transferred to the archives. (1976, c. 746; 1977, c. 501; 1981, c. 637; 1990, c. 778.)

The 1990 amendment substituted "Council" for "Committee" in the introductory language; redesignated former subdivisions A through C as present subdivisions 1 through 3; deleted "designed" preceding "to facilitate the creation" in the first sentence of subdivision 1; in subdivision 2 divided the former second sentence into the present second and third sentences by deleting "except that" at the end of the present second sentence, and deleted "not" preceding "apply to clerks of courts of record" in the present last sentence, and in the last sentence of the first paragraph of subdivision 3, substituted "without being first offered" for "without having first offered," deleted "it" following "first offered," and substituted "State Library and Archives" for "State Library."

§ 42.1-83. Program for inventorying, scheduling, microfilming records; records of counties and cities; storage of records. — The State Library Board shall formulate and execute a program to inventory, schedule, and microfilm official records of counties and cities which it determines have permanent value and to provide safe storage for microfilm copies of such records, and to give advice and assistance to local officials in their programs for creating, preserving, filing and making available public records in their custody.

Any original records shall be either stored in the State Library and Archives or in the locality at the decision of the local officials responsible for maintaining public records. Any original records shall be returned to the locality upon the written demand of the local officials responsible for maintaining local public records. Microfilm shall be stored in the State Library and Archives but the use thereof shall be subject to the control of the local officials responsible for maintaining local public records. (1972, c. 555; 1976, c. 746.)

§ 42.1-84. Same; records of agencies and subdivisions not covered under § 42.1-83. — The State Library Board may formulate and execute a program of inventorying, repairing, and microfilming for security purposes the public records of the agencies and subdivisions not covered under the program established under § 42.1-83 which it determines have permanent value, and of providing safe storage of microfilm copies of such records. (1976, c. 746.)

§ 42.1-85. Duties of State Librarian; agencies to cooperate; agencies to designate records officer. — The State Librarian shall administer a records management program for the application of efficient and economical management methods to the creation, utilization, maintenance, retention, preservation, and disposal of public records consistent with rules, regulations, or standards promulgated by the State Library Board, including operations of a records center or centers. It shall be the duty of the State Librarian to establish procedures and techniques for the effective management of public records, to make continuing surveys of paper work operations, and to recommend improvements in current records management practices, including the use of space, equipment, and supplies employed in creating, maintaining, and servicing records.

It shall be the duty of any agency with public records to cooperate with the State Librarian in conducting surveys and to establish and maintain an active, continuing program for the economical and efficient management of the records of such agency.

Each state agency and political subdivision of this Commonwealth shall designate as many as appropriate, but at least one, records officer to serve as a liaison to the State Library and Archives for the purposes of implementing and overseeing a records management program, and coordinating legal disposition, including destruction of obsolete records. Designation of state agency records officers shall be by the respective agency head. Designation of a records officer for political subdivisions shall be by the governing body or chief administrative official of the political subdivision. (1976, c. 746; 1990, c. 778.)

The 1990 amendment added the last paragraph.

§ 42.1-86. Program to select and preserve important records; availability to public; security copies. — In cooperation with the head of each agency, the State Librarian shall establish and maintain a program for the selection and preservation of public records considered essential to the operation of government and for the protection of the rights and interests of persons. He shall provide for preserving, classifying, arranging, and indexing so that such records are made available to the public and shall make security copies or designate as security copies existing copies of such essential public records. Security copies shall be of archival quality and shall be made by photographic, photostatic, microfilm, microcard, miniature photographic, or other process which accurately reproduces and forms a durable medium. Security copies shall have the same force and effect for all purposes as the original record and shall be as admissible in evidence as the original record whether the original record is in existence or not. Security copies shall be preserved in the place and manner prescribed by the State Library Board and the Governor. Public records deemed unnecessary for the transaction of the business of any agency, yet deemed to be of administrative, legal, fiscal, or historical value, may be transferred with the consent of the State Librarian to the custody of the State Library and Archives. (1976, c. 746; 1980, c. 365; 1990, c. 778.)

The 1990 amendment deleted "or cause to be made" preceding "security copies or designate as security copies" in the second sentence, divided the former third sentence into the present third and fourth sentences by deleting "and" at the end of the present third sentence and by adding "Security copies" at the beginning of the present fourth sentence, in the present third sentence, inserted "shall be" preceding "made," and deleted "such copies" preceding "shall be made," in the present fifth sentence, deleted "Such" preceding "Security copies," substituted "the place" for "such place," deleted "of safekeeping as" preceding "prescribed by the State Library Board," and deleted "provided by" preceding "the Governor," in the present last sentence, deleted "Those " preceding "Public records" and substituted "State Library and Archives" for "State Library," and deleted the former last sentence which stated: "No agency shall destroy, discard, sell or give away public records without first offering them to the State Library for preservation."

§ 42.1-86.1. Disposition of public records. — No agency shall destroy or discard public records without a retention and disposition schedule approved by the State Librarian as provided in § 42.1-82. No agency shall sell or give away public records. (1990, c. 778.)

§ 42.1-87. Where records kept; duties of agencies; repair, etc., of record books; agency heads not divested of certain authority. — Custodians of public records shall keep them in fireproof safes, vaults or in rooms designed to ensure proper preservation and in such arrangement as to be easily accessible. Current public records should be kept in the buildings in which they are ordinarily used. It shall be the duty of each agency to cooperate with the State Library and Archives in complying with rules and regulations promulgated by the Board. Each agency shall establish and maintain an active and continuing program for the economic and efficient management of records.

Record books should be copied or repaired, renovated or rebound if worn, mutilated, damaged or difficult to read. Whenever the public records of any public official are in need of repair, restoration or rebinding, a judge of the court of record or the head of such agency or political subdivision of the Commonwealth may authorize that the records in need of repair be removed from the building or office in which such records are ordinarily kept, for the length of time necessary to repair, restore or rebind them, provided such restoration and rebinding preserves the records without loss or damage to them. Any public official who causes a record book to be copied shall attest it and shall certify an oath that it is an accurate copy of the original book. The copy shall then have the force of the original.

Nothing in this chapter shall be construed to divest agency heads of the authority to determine the nature and form of the records required in the administration of their several departments or to compel the removal of records deemed necessary by them in the performance of their statutory duty. (1976, c. 746.)

§ 42.1-88. Custodians to deliver all records at expiration of term; penalty for noncompliance. — Any custodian of any public records shall, at the expiration of his term of office, appointment or employment, deliver to his successor, or, if there be none, to the State Library and Archives, all books, writings, letters, documents, public records, or other information, recorded on any medium kept or received by him in the transaction of his official business; and any such person who shall refuse or neglect for a period of ten days after a request is made in writing by the successor or State Librarian to deliver the public records as herein required shall be guilty of a Class 3 misdemeanor. (1976, c. 746.)

Cross references. — As to punishment for Class 3 misdemeanors, see § 18.2-11.

§ 42.1-89. Petition and court order for return of public records not in authorized possession. — The State Librarian or his designated representative such as the State Archivist or any public official who is the custodian of public records in the possession of a person or agency not authorized by the custodian or by law to possess such public records shall petition the circuit court in the city or county in which the person holding such records resides or in which the materials in issue, or any part thereof, are located for the return of such records. The court shall order such public records be delivered to the petitioner upon finding that the materials in issue are public records and that such public records are in the possession of a person not authorized by the custodian of the public records or by law to possess such public records. If the order of delivery does not receive compliance, the plaintiff shall request that the court enforce such order through its contempt power and procedures. (1975, c. 180; 1976, c. 746.)

§ 42.1-90. Seizure of public records not in authorized possession. — A. At any time after the filing of the petition set out in § 42.1-89 or contemporaneous with such filing, the person seeking the return of the public records may by ex parte petition request the judge or the court in which the action was filed to issue an order directed at the sheriff or other proper officer, as the case may be, commanding him to seize the materials which are the subject of the action and deliver the same to the court under the circumstances hereinafter set forth.

B. The judge aforesaid shall issue an order of seizure upon receipt of an affidavit from the petitioner which alleges that the material at issue may be sold, secreted, removed out of this Commonwealth or otherwise disposed of so as not to be forthcoming to answer the final judgment of the court respecting the same; or that such property may be destroyed or materially damaged or injured if permitted to remain out of the petitioner's possession.

C. The aforementioned order of seizure shall issue without notice to the respondent and without the posting of any bond or other security by the petitioner. (1975, c. 180; 1976, c. 746.)

§ 42.1-91. Development of disaster plan. — The State Library and Archives shall develop a plan to ensure preservation of public records in the event of disaster or emergency as defined in § 44-146.16. This plan shall be coordinated with the Department of Emergency Services and copies shall be distributed to all agency heads. The personnel of the Library shall be responsible for coordinating emergency recovery operations when public records are affected. (1981, c. 637.)

DOCUMENTATION BY EXCEPTION

The Virginia Department of Health accepted documentation by exception as the preferred method for recording in the clinical record. A multidisciplinary team appointed by the Nursing Council used the tools and philosophy of total quality management to design the system. The Council charged the team with the following objectives:

- To reduce the number of forms.
- To eliminate unnecessary duplication.
- To improve user satisfaction.
- To design a system that is legally defensible.
- To make information easily retrievable.
- To reduce provider time in documentation.
- To develop a system that could be automated.

The team collected random sample data from a user satisfaction survey, a time study, a chart audit, and by collecting locally developed forms to identify problems from the user's perspective. More than eighty per cent of the users were dissatisfied or very dissatisfied with the present system. They identified duplication and too many forms as major problems. The chart audits confirmed that vital information was either missing or difficult to find. Users spent an average of 41% of their time documenting in the clinical record. Six hundred and sixty-three locally developed forms were collected from eighteen of the thirty-five districts.

Following review of several possible systems, the team chose documentation by exception. Basically, we adapted an acute care model to public health. We chose a motto coined by one of the staff nurses, "Ask one time. Answer one time. Record one time." If the system components did not pass that test, we went back into the design phase.

The system is based on standards that define acceptable practice; minimum program requirements; and normal parameters for assessment, examination, intervention, expected patient responses and outcomes. The system does not require nursing care plans in every chart as the standards include appropriate parameters for using the nursing process.

The baseline of service is defined for every patient served in any health department in Virginia. If the provider gives that baseline level of service, flow sheets can be used to note assessment, examination, intervention and expected patient responses in the areas indicated by using a check mark. An asterisk indicates that the patient response was not normal or the provider omitted something that is required by the standard.

PROVIDER STANDARDS OF CARE
VIRGINIA DEPARTMENT OF HEALTH

Provider standards of care are the standards which govern services received by individuals and families from health departments in Virginia. Each program has written standards that are based on the protocol manual for that particular program, but may include other resources to ensure an acceptable level of practice. All standards are intended to be multi-disciplinary plans of care with each clinician collaborating with all providers and the client to meet identified needs. The role of each provider is determined by the scope of practice of the discipline and the personnel policies of the Department of Health. Standards and the documentation system must be reviewed annually to ensure acceptable practice.

Core components of standards are assessment parameters and interventions that determine the acceptable level of care that must be provided to achieve desired outcomes.

Baseline parameters for normal adult male, female and pediatric physical exams are included in the Exception Documentation Guidelines.

Normal values for laboratory test results will be determined by the laboratory performing the test.

Interventions are a comprehensive list. Provider judgment will dictate appropriate interventions and frequency of monitoring.

Specific nurse practitioner and physician orders may supersede written standards with supporting documentation.

SOC-96

INSTRUCTIONS: VDH STANDARD PLAN OF CARE/ SUMMARY OF PROVIDERS OF CARE

Purpose:

To be used for all client records to reference plan of care changes, and to record signatures, titles, and initials of providers writing in the record.

Plan of Care

Start Date:

Enter the date the client is assessed, a health care need is identified, and a standard of care is chosen to meet that need.

Standard:

Enter the title of the standard of care being referenced. If a standard of care is referenced, a care plan will not be written in the record. The standard entered here must match the title of the standard from the Standards Manual or a local standard. Examples: A client receiving service for a method of contraception will be referenced to the Family Planning standard--not contraception. A client receiving prenatal care will be referenced to the Maternity standard. Since nutrition is a component of each of these standards, nutrition will not be referenced separately.

NOTE: If a standard is not in existence that will adequately help the provider meet the client's needs, formulate a plan of care and write it in this space. If more space is needed use additional forms.

Stop Date:

Enter the date when this standard is no longer applicable to the client, when the client's needs have changed. Example: a maternity client who has delivered and then comes to family planning clinic has a stop date entered for the Maternity standard, then a start date for Family Planning and Family Planning entered as the standard.

Note: a focus of care for each visit is to be entered on the appropriate visit record. This is not the standard, but rather the focus for that particular day's visit.

SUMMARY OF PROVIDERS

This must be completed only once by those providers documenting in the record.

Initials:

Enter your initials.

Signature:

Sign your name and title.

Printed name:

Print your full name and title legibly.

I-Form 96-1

VIRGINIA DEPARTMENT OF HEALTH
VDH STANDARD PLAN OF CARE

For reference see Virginia Department of Health Standards of Care:

Start Date	Standard of Care	Stop Date

SUMMARY OF PROVIDERS OF CARE

Initials	Signature/Title	Printed Name/Title

NAME:
ID#

Form 96-1

Virginia Department of Health
Standards of Care: Sexually Transmitted Diseases

Quality Standard: Clients seeking or referred for diagnosis and treatment of sexually transmitted diseases can expect assessment, medical evaluation and treatment or appropriate referral, risk reduction counseling, and partner referral services.

The basis for the **core components of standards** in the Virginia Department of Health Sexually Transmitted Diseases/HIV Program is Part II., Clinic Protocols for Patient Management, Pg. 30-43, Sexually Transmitted Disease Manual, 1994, published by the Office of Epidemiology Bureau of Sexually Transmitted Diseases/AIDS.

Clients utilizing the STD Services will receive no less than the following care components which are considered **acceptable practice**:

Assessment
The basic STD medical history and risk assessment must be conducted in addition to the basic physical examination and routine laboratory specimen collection as indicated in the manual reference identified above.

Intervention
Decisions about a client's stage of disease and treatment plan must be based on optimal standards of care. Treatment should follow "STD Diagnosis/Treatment Guidelines 1993" (see Diagnosis/Treatment, Sexually Transmitted Disease Manual) and should involve the client in decision-making regarding his/her care.

Referral practices must follow the standards in the STD Manual referenced above.

Risk reduction counseling/education standards must be client based and must include information about the disease diagnosed, transmission, incubation period, infectious period, complications and necessity for referral of sex partners to care. When medication is provided, appropriate teaching must occur according to the standards for medications. All clients must also receive HIV risk-reductions messages as outlined in the STD Manual ,(see HIV Counseling, PreTest HIV Antibody Counseling Guide.)

Outcome
Outcome criteria include clients becoming non-infectious through treatment and clients either referring their partners for evaluation or receiving partner referral services.

SOC-STD-96

VDH STD CONFIDENTIAL HEALTH HISTORY

Please answer all questions to help us serve you better.

DO NOT WRITE BELOW THIS LINE.

Exception Notes

•• ALL ANSWERS ARE CONFIDENTIAL. ••

1. Why did you come to the clinic today?
   - ___ I have _____.
   - ___ I want a STD check-up.
   - ___ Someone told me to come. Who? _____
   - ___ I had sex with someone who has
     - ___ Gonorrhea (GC, Clap)
     - ___ Chlamydia
     - ___ Syphilis
     - ___ Trichomonas
     - ___ HIV/AIDS
     - ___ Other What? _____

2. Please check all the symptoms you have:
   - ___ None
   - ___ Rash
   - ___ Discharge
   - ___ Burning with urination
   - ___ Abdominal pain
   - ___ Sore, Cut, Bump
   - ___ Other What? _____

3. Are you taking any medicines? No ___ Yes___ What: _____

4. Are you allergic to any medicines? No ___ Yes___ What: _____

5. List any problems your partner (s) has now: _____
   _____

6. How many persons have you had sex with in the last 30 days? _____

7. When was the last time you had sex with anyone? _____

8. Check all the infections you have had in the past:
   - ___ Syphilis
   - ___ Trichomonas
   - ___ Pelvic infection
   - ___ Gonorrhea
   - ___ Chlamydia
   - ___ Warts
   - ___ Herpes
   - ___ HIV
   - ___ AIDS
   - ___ other - What? _____

9. What kinds of sex have you had?
   - ___ Penis to vagina
   - ___ Penis to rectum
   - ___ Mouth to penis
   - ___ Mouth to vagina

10. How often do you drink alcohol? _____ How much? _____

11. How often do you use street drugs? _____

12. What street drugs do you use? _____

13. What do you do to keep from getting AIDS? _____

FOR WOMEN ONLY:

14. What was the first day of your last period? _____

15. Was it a normal period for you? No ___ Yes ___

16. Are your periods regular? No ___ Yes ___

17. Do you think you are pregnant? No ___ Yes___

18. What do you do to keep from getting pregnant? _____

DATE REVIEWER

_____ _____

_____ _____

SIGNED: _____ DATE: _____

NAME
ID#

FORM 96-STD-1

INSTRUCTIONS: VDH STD CONFIDENTIAL HEALTH HISTORY

Purpose: To be used for initial visit for screening, diagnosis and treatment of sexually transmitted diseases.

This form is to be completed by the client being admitted on the first visit per episode of disease. This is then to be reviewed by a health care professional who will make any notes necessary and date and initial for completion of the review. Client will need to complete this health history even though a current Form 96-2 VDH Confidential Health History may be in client's health department medical record, as information is specific to time period and behavior related to the infection or problem for which care is being sought.

I-Form 96-STD-1

VDH SEXUALLY TRANSMITTED DISEASE VISIT RECORD

	MEASUREMENT/EXCEPTION NOTES	MEASUREMENT/EXCEPTION NOTES
DATE REASON FOR VISIT HEALTH STATUS CHANGES BLOOD PRESSURE FOCUS OF CARE		
SKIN NODES ORAL CAVITY ANUS/PERIANAL AREA OTHER_____ FEMALE: VULVA VAGINA CERVIX BIMANUAL MALE: PENIS TESTICLES EXAMINER INITIALS		
STAIN-URETHRAL GC CULTURE CHLAMYDIA STS _____ *X if done* WHA-TP/FTA NET PREP KOH HIV ANTIBODY OTHER _____	SITES:_____	SITES: _____
DIAGNOSIS/IMPRESSION MEDICATION ORDER *X = Ordered*	_____TEST ONLY_____ AMOXICILLIN 500 MG PO TID X ___ DAYS CIPRO 500 MG PO CEFTRIAXONE ___ MG IM METRONIDAZOLE 2 GM PO OR 500 MG PO BID X 7 DAYS BICILLIN: 2.4 MIL UNITS IM WEEKLY X ___ SPECTINOMYCIN 2 GM IM DOXYCYCLINE 100 MG PO BID X __ DAYS ERYTHROMYCIN ___ MG PO QID X __ DAYS PODOPHYLLIN TOPICAL WEEKLY X ____ TCA TOPICAL WEEKLY X ____ VAGINAL CREAM_____ ___X WK AZITHROMYCIN ____ MG OTHER _____	_____TEST ONLY_____ AMOXICILLIN 500 MG PO TID X ___ DAYS CIPRO 500 MG PO CEFTRIAXONE ___ MG IM METRONIDAZOLE 2 GM PO OR 500 MG PO BID X 7 DAYS BICILLIN: 2.4 MIL UNITS IM WEEKLY X ___ SPECTINOMYCIN 2 GM IM DOXYCYCLINE 100 MG PO BID X __ DAYS ERYTHROMYCIN ___ MG PO QID X __ DAYS PODOPHYLLIN TOPICAL WEEKLY X ____ TCA TOPICAL WEEKLY X ____ VAGINAL CREAM_____ ___X WK AZITHROMYCIN ____ MG OTHER _____
SIGNATURE OF CLINICIAN DISPENSED/ADMINISTERED(SIGNATURE) SPECIAL INSTRUCTIONS	Site if IM:	Site if IM:
TEACHING: SIDE EFFECTS PREVENTION COUNSELING PARTNER REFERRAL REFERRALS/RTC INITIALS OF POSTING PROVIDER		
FOLLOW UP: DIAGNOSIS/FOCUS MEDICATION/ADMINISTERED INSTRUCTIONS REFERRAL/RTC	DATE: BY:	DATE: BY:
DIAGNOSIS/FOCUS MEDICATION/ADMINISTERED INSTRUCTIONS REFERRAL/RTC	DATE: BY:	DATE: BY:

ALLERGIES_____

N/y = Normal
** = Variance from Normal*
No entry = Not required
X = Lab test done or medication ordered

Name
ID #

FORM 96-STD-2

INSTRUCTIONS: VDH SEXUALLY TRANSMITTED DISEASE VISIT RECORD

Purpose:

To be used for initial and follow-up visits for diagnosis and treatment in sexually transmitted disease clinics.

Assessment:

Enter the date of the visit and the reason the client gives for being in clinic that day.
Enter medication allergies at bottom of form in space provided.
List health status changes since last visit, if repeat visit. Record BP.
Focus of Care refers to the plan of care for the client for this visit only and will be based on symptoms and history from self-administered STD Confidential Health History.

Physical exam assessment parameters are listed in the "Standards of Care: Normal Male/Female Adult Exam." A ✓ indicates the assessment was done and no variance from normal was found. An * indicates variance from normal and requires documentation in exception notes. No entry indicates that the item is not required by the standard. The examining clinician signs in the space provided.

An X indicates lab work is done or a procedure ordered (such as chest x-ray). Record results of stat tests in the space provided. Post/File results for non-stat tests and procedures in the client record on Laboratory Reports Record CHS-9.

When using the" Other_____" slot to designate additional lab test, place an X in the box beside "Other _____" and write the name of the test in the blank. If this is the second visit on the record and those spaces are used, designate the name of the test to the right of the box in the Exception Notes section.

Intervention:

The clinician lists the diagnosis, (or X if test only), medications order and any instructions to the patient in spaces provided. The clinician signs in the space provided. The clinician dispensing or the nurse administering medication signs in the space provided.

A ✓ indicates teaching and partner referral occurred. Exception note section should indicate if partner referral is to be self referral or referral by health department staff.

Any other referrals or appointment to return to clinic will be documented in space provided for exception note. If more space is required for referral note, use Communication/Exception Record. The posting provider initials record in space provided.

Follow-up:

Return to clinic for test results, post-counseling or additional mediaction will be recorded in this section. Where medication is given, administering clinician will indicate medication and sign. Medical, social sevices, or other referral, such as for HIV + patients, will be entered in the referral/RTC space and continued on Communication/Exception Record if necessary.

VDH WART TREATMENT FLOW SHEET

DATE

□ PODOPHYLLUM-APPLY TO WARTS TOPICALLY
PRN X _____

□ TCAA - APPLY TO WARTS TOPICALLY
PRN X _____

MD/CNP SIGNATURE:_____

LMP:_____LAST SEX:_____
BIRTH CONTROL METHOD:_____
WARTS: □ IMPROVED □ SAME □ WORSE
MEDS APPLIED: □PODO □ TCAA □BAKING SODA
□ INSTRUCTED TO WASH OFF IN 3-4 HOURS
RETURN TO CLINIC:_____
COMMENTS_____
SIGNATURE:_____

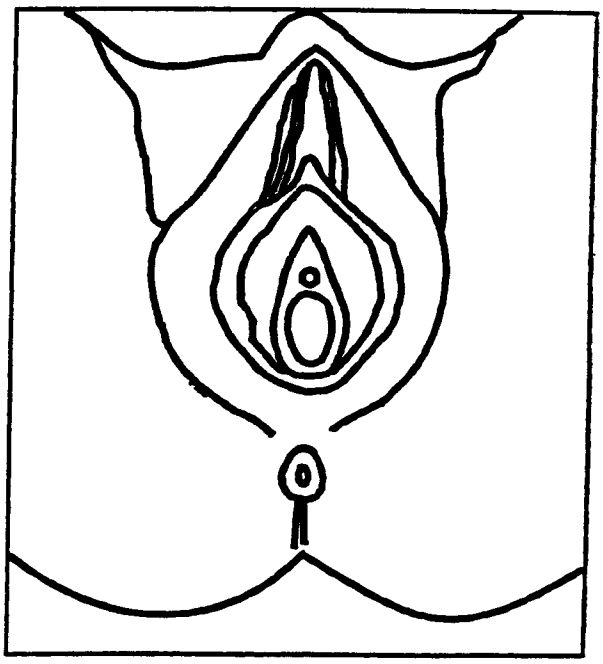
= =

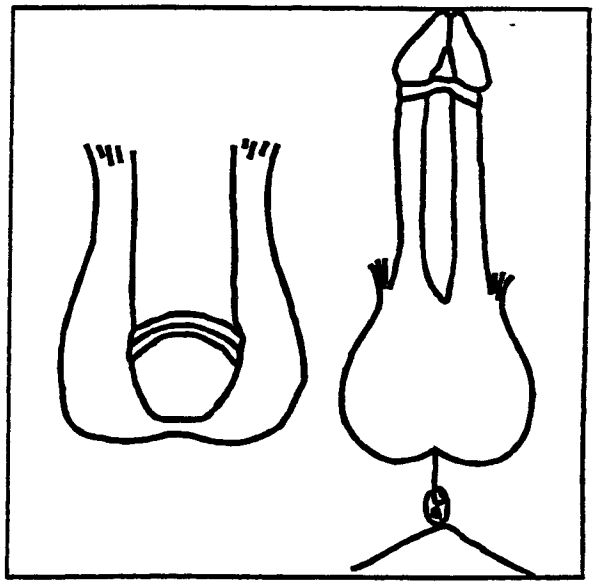
LMP:_____LAST SEX:_____
BIRTH CONTROL METHOD:_____
WARTS: □ IMPROVED □ SAME □ WORSE
MEDS APPLIED: □ PODO □TCAA □BAKING SODA
□ INSTRUCTED TO WASH OFF IN 3-4 HOURS
RETURN TO CLINIC:_____
COMMENTS_____
SIGNATURE:_____
= =

LMP:_____LAST SEX:_____
BIRTH CONTROL METHOD:_____
WARTS: □IMPROVED □SAME □ WORSE
MEDS APPLIED: □PODO □TCAA □BAKING SODA
□ INSTRUCTED TO WASH OFF IN 3-4 HOURS
RETURN TO CLINIC:_____
COMMENTS:_____
SIGNATURE:_____
= =

LMP:_____LAST SEX:_____
BIRTH CONTROL METHOD:_____
WARTS: □IMPROVED □SAME □WORSE
MEDS APPLIED: □PODO □TCAA □BAKING SODA
□ INSTRUCTED TO WASH OFF IN 3-4 HOURS
RETURN TO CLINIC:_____
COMMENTS:_____
SIGNATURE::_____

= =



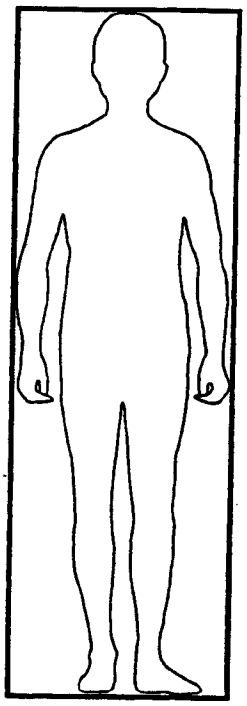


FORM 96-STD-3

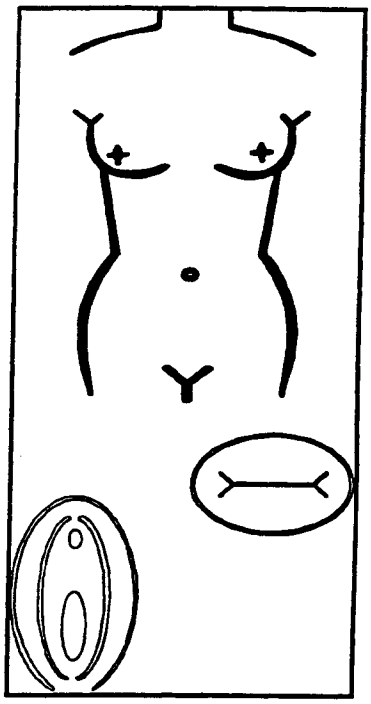
NAME
ID#

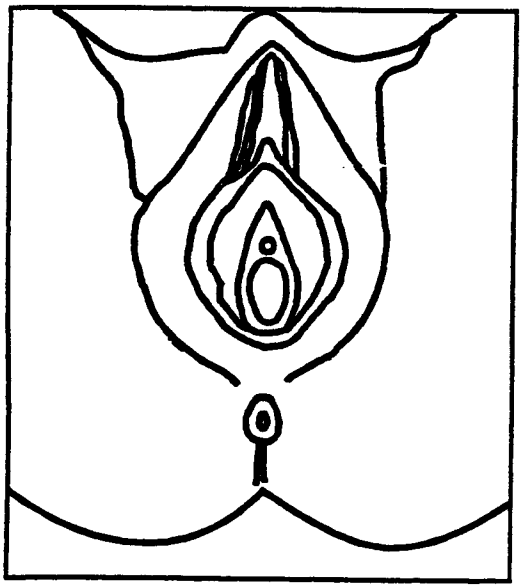
VDH ANATOMICAL SUPPLEMENT

A.



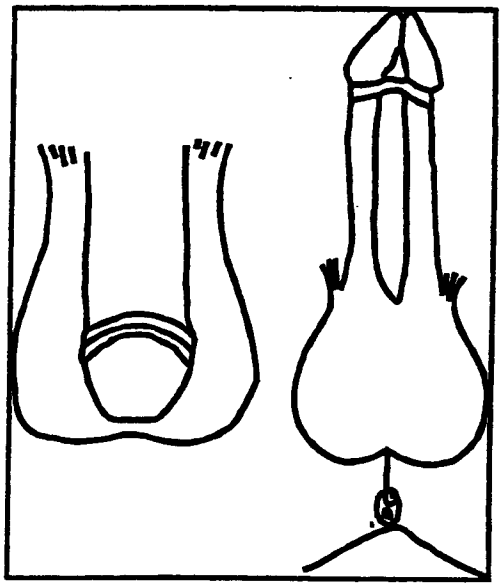
B.





C.

D.



Date: _____

Exception Notes: _____

_____

_____

INSTRUCTIONS: VDH ANATOMICAL SUPPLEMENT

Purpose:

This form will provide simple anatomical diagrams on which may be recorded significant findings for scars, rashes, lesions, warts, etc. It may be added to a client record if needed and updated by adding a new form when neccesary.

Date the record when recording the finding. Exception note should refer to the appropriate drawing being recorded on by letter.

I-FORM 96-7

VDH COMMUNICATION/EXCEPTION RECORD

DATE	TYPE	NOTE/FOCUS OF CARE	INITIALS

TYPE OF CONTACT:

PC = phone call
/ = home visit
o/ = office visit
FV = field visit
SV = school visit
CV = clinic visit
EX = exception note
TC = team conference
OT = any other contact or communication

Label Name and I.D. #

Form 96-4

INSTRUCTIONS: VDH COMMUNICATION/EXCEPTION RECORD

Purpose:

To be used to record encounters outside of clinic, client-related communication and as additional space to record variances from normal. Documentation is intended to be concise and clear.

Date and Type:

Enter date and type of contact in the space provided using the legend at bottom of the form. If documenting a variance from normal for a clinic visit (or continuing an exception note from a visit record, enter the date of the clinic visit and "CV" for the type of contact.

NOTE: If the physician is using the exception record for writing a prescription or medication order, physician's full signature is required.

Note/Focus of Care:

Record key phrases that describe the communication, encounter, or variance from normal. If used for a short encounter, the provider should record a focus of care for the visit.

Initials:

The initials of the provider are recorded here. The provider must be identified by signature and initials on the Summary of Providers form.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF GENERAL SERVICES
DIVISION OF CONSOLIDATED LABORATORY SERVICES

CHLAMYDIA FORM AND REPORT

FOR LAB USE ONLY CODES ON REVERSE

Lab No.	Code No.	Specimen No.
Date Rec'd		Time AM PM

PATIENT'S NAME LAST	FIRST	MIDDLE	Married ☐ Yes ☐ No ☐ Unknown	Age	Date of Birth	RACE ☐ B ☐ Hisp ☐ W ☐ Asia/PI ☐ O ☐ AI/AN	Sex ☐ M ☐ F
ADDRESS	CITY/COUNTY	STATE ZIP CODE					

Submitter Code # _____

Collected by: _____

PIN # _____ Satellite Clinic _____ PHYSICIAN OR AUTHORIZED PERSON: _____

Patient Telephone ( ) _____ REPORT TO: SUBMITTER _____

ADDRESS _____

CITY _____

STATE _____ ZIP CODE _____

TYPE OF SERVICE
- ☐ PRI PHYS
- ☐ FAM PLAN
- ☐ PRENATAL
- ☐ JOB CORPS
- ☐ STD CLINIC
- ☐ OTHER (SPECIFY) _____
- ☐ GYNECOLOGIC
- ☐ COMMUNITY H.C.
- ☐ STUDENT H.C.
- ☐ YOUTH DET CTR
- ☐ JAIL/CORRECTIONS

DATE COLLECTED: _____ DATE SUBMITTED: _____

REASON FOR EXAM (check all that apply)
- ☐ SCREENING
- ☐ DIAGNOSIS
- ☐ ANNU. RESCREEN
- ☐ CONTACT TO STD
  Please specify _____
- ☐ OTHER _____

SOURCE OF SPECIMEN (check only one)
- ☐ CERVIX
- ☐ URETHRA (Male)
- ☐ RECTUM
- ☐ THROAT
- ☐ OTHER _____
- ☐ CONJUNCTIVAL

CLINICAL PRESENTATION (check all that apply)
- ☐ NORMAL EXAM
- ☐ CERVICITIS
- ☐ FRIABLE CERVIX
- ☐ DYSURIA
- ☐ DISCHARGE - MUCOPURULENT
- ☐ OTHER (SPECIFY) _____

RISK INFORMATION (check all that apply)
- ☐ < 25 YEARS OF AGE
- ☐ NEW SEX PTNR PREV 90 DAYS
- ☐ > 1 SEX PTNR PREV 90 DAYS
- ☐ INCONSISTENT USE OF BARRIER CONTRACEPTIVES
- ☐ OTHER

RISK REDUCTION COUNSELING?
☐ YES ☐ NO

WAS PATIENT PRESUMPTIVELY TREATED?
☐ YES ☐ NO

DGS - 22-190 REVISED 3/94

LEGAL CASE - CHAIN OF CUSTODY (Y/N) ____

DO NOT WRITE IN SPACE BELOW – FOR LAB USE ONLY

LABORATORY TEST RESULTS

CHLAMYDIA
- ☐ POSITIVE CONFIRMED
- ☐ NEGATIVE
  (A negative test result does not always preclude Chlamydia Infection. Proper specimen collection and handling is essential to obtain an accurate test result)
- ☐ SPECIMEN EXPIRED
- ☐ UNSATISFACTORY (Submit additional specimen)
- ☐ NO COLLECTION DATE (Results may be invalid)

TYPE OF TEST
- ☐ EIA
- ☐ DNA TECHNOLOGY
- ☐ CULTURE
- ☐ DFA
- ☐ OTHER SPECIFY _____

DATE REPORTED _____
TIME _____ AM ___ PM ___
INITIAL _____
REVIEWED _____

SPECIMEN	CHART	LAB ONLY

HEALTH PROVIDER

Chlamydia Laboratory Report Form Completion

The Commonwealth of Virginia Chlamydia Laboratory Report Form is intended to provide users with the opportunity to report screening, counseling, diagnosis, and treatment activity in a single form. The five-part form provides laboratory results to: 1) The examining physician or medical facility to complete his/her diagnosis and morbidity report, 2) The local health department, if test is positive, 3) The processing laboratory for a permanent record, and 4) The State Department of Health for morbidity and surveillance purposes.

Patient Information:

- **Name:** - Enter the patient's last name, first name, followed by middle initial.
- **Address:** - Enter the street address, apartment number, etc.
- **City/County:** - Enter the appropriate information; important for locating and epidemiological evaluation purposes.
- **Married:** - Check appropriate box.
- **Age/Date of Birth:** - MANDATORY FIELD- this information is necessary for updating screening records with diagnosis/treatment data, as well as for epidemiological evaluation.
- **Race:** - Indicate the following: B = Black; W = White; O = Other, Hisp = Hispanic, Asia/PI = Asian/Pacific Islander, AI/AN = American Indian/Alaskan Native.
- **Sex:** - Check appropriate box.
- **Submitter Code #:** - Enter the locality's 3-digit FIPS code.
- **Collected by:** - Enter the last name of the clinician performing the specimen collection.
- **PIN#** - For those localities that utilize PIN numbers, enter the number here; otherwise, leave blank.
- **Satellite Clinic:** - For those localities with additional clinic sites besides the primary clinic address, enter the name of the satellite clinic.
- **Physician Or Authorized Person:** - Enter the name of clinician or health director, as appropriate.
- **Patient Telephone:** - Enter the patient's home telephone number.
- **Report to:** - Enter the name and address to whom the test results will be returned.

Type of Service:

- ✓ **Check the box which best describes the type of health care provider obtaining the culture specimen.**

Reason for Exam: ~ (CHECK ALL THAT APPLY)

- **Screening:** - Check this box if the test is done as a result of routine Chlamydia testing of all women meeting the age-based screening criteria who receive a pelvic examination.
- **Diagnosis:** - Check this box if the clinician performs the test because of suspicion of Chlamydia infection.
- **Annual Re-Screen:** - Check this box if the purpose of the visit is for a yearly evaluation.
- **Contact-STD:** - Check this box if the patient is known to be a contact to a STD, and specify the infection.

Source of Specimen:

- **Cervix:** - Recommended primary site for obtaining Clamydia specimen.
- **Rectum:** - Best collected via anoscopy with sampling from area of erythema, friability, and mucopus.
- **Urethra:** - Primary site for obtaining a specimen from a male.
- **Throat:** - Primary site based on sexual history.
- **Conjunctival:**
- **Other:** - For sites not indicated above.

Clinical Presentation:

- **Cervicitis:** - Edema, erythema, or follicle-like lesions in an area of ectopy (the extension of columnar epithelium onto the ectocervix).
- **Discharge-Mucopurulent:** - The presence of endocervical mucopus; green or yellow discharge when viewed on a white swab that has been inserted into the cervical os.
- **Friable Cervix:** - Easily induced bleeding on the exocervix or from the canal associated with the collection of specimens from the os. Bleeding associated with the use of a cytobrush is not considered an indication of friability and should not be reported.
- **Dysuria:** - Patient complains of burning on urination.

Risk Information : ~ (CHECK ALL THAT APPLY)

- **Check any box that accurately reflects this patient's history.**

Risk Reduction Counseling?:

- Check "Yes" if patient received risk reduction counseling during this clinic visit; otherwise, check "No".

Patient Presumpively Treated?:

- Check "Yes" if patient received treatment ON THIS VISIT as a result of the clinician's decision based on clinical presentation OR based on the "STD" Contact" history of exposure to Chlamydia/GC, otherwise check "No".

Legal Case Chain of Custody?:

- Circle "Yes" if the test was obtained as a result of a legal investigation and chain of custody protocol was followed; otherwise circle "No".

Morbidity Report: ~ (Located on the "Health Provider - when positive" copy (copy 5) of the laboratory report form):

- **Use this section to indicate diagnosis and treatment schedule, including date treated. For "Patient/Partner Referral", indicate if the patient was advised by a sex partner to seek medical evaluation and treatment for Chlamydia.**

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF GENERAL SERVICES
DIVISION OF CONSOLIDATED LABORATORY SERVICES
BUREAU OF MICROBIOLOGICAL SCIENCES

BRANCH AND AFFILIATED LABORATORIES

FOR LAB USE ONLY

LAB NO.	SPECIMEN NO.

DATE RECEIVED: ____/____/____

GONORRHEA CULTURE FORM AND REPORT

PLEASE TYPE OR PRINT WITH A BALL POINT PEN ON A HARD SURFACE. PREPARE A SEPARATE FORM FOR EACH SPECIMEN.

PATIENT'S NAME LAST	FIRST	MIDDLE	MARRIED	AGE	RACE	SEX
			❑ YES ❑ NO ❑ UNKNOWN			

ADDRESS STREET _____ CITY / COUNTY _____ STATE _____ ZIP CODE _____

TELEPHONE NO. (____) _____

REPORT TO:

TYPE OF SERVICE

❑ PRI PHYS
❑ FAM PLAN
❑ PRENATAL OB / GYN
❑ MANPWR TRN.
❑ VD-CLINIC
❑ CANCER DET
❑ GYNECOLOGIC
❑ GROUP H.C.
❑ STUDENT H.C.
❑ JAIL / DET CTR
❑ OTHER
_____ specify

Submitter _____

Address _____

City _____ State _____

Zip Code _____

REASON FOR EXAM:

❑ TEST-OF-CURE
❑ SCREENING
❑ DIAGNOSIS
❑ CONTACT-GC

SOURCE OF SPECIMEN:

❑ CERVIX
❑ RECTUM
❑ THROAT
❑ URETHRA (MALE)
❑ OTHER (specify below)
_____

DATE COLLECTED: ____/____/____

DATE SUBMITTED: ____/____/____

DGS-22-065 (REVISED 01/89)

DO NOT WRITE IN SPACE BELOW – FOR LAB USE ONLY

LABORATORY TEST RESULTS

❑ Negative
❑ Unsatisfactory _____
_____
❑ Presumptive positive GC
❑ Confirmed GC
❑ Beta Lactamase negative
❑ Beta Lactamase positive
❑ Other Neisseria species

ANTIMICROBIAL SUSCEPTIBILITY:

Penicillin _____
Tetracycline _____
Spectinomycin _____
Other _____

DATE REPORTED: ____/____/____

INITIAL: _____

HEALTH PROVIDER

DGS-22-065

Note: The Gonorrhea culture report form (DGS-22-065) will remain in use; those areas served by the 11 affiliate labs will be utilizing a new form (being developed as a result of CLIA requirements) that contains the lab's name. A draft copy is included for your review, and will be mailed to holders of STD manuals when available.

Gonorrhea Culture Report Form Completion

The Gonorrhea culture report form is intended to provide local health departments, physicians, hospitals and other medical facilities who participate in the statewide gonorrhea screening program, with a standard laboratory specimen slip. The five-part form is designed to provide laboratory results to: 1) The examining physician or medical facility to complete his/her diagnosis and morbidity report, 2) The local health department, if test is positive, 3) The processing laboratory for a permanent record and 4) The State Department of Health for morbidity and surveillance purposes.

Patient Information:

- **Name:** - Enter the patient's last name, first name, followed by middle initial.
- **Address:** - Enter the street address, apartment number, etc.
- **City/County:** - Enter the appropriate city (name of city required for follow-up and residence code).
  - ➢ It is important to use the patient's address in order to assign morbidity to the proper location. If the address is missing then morbidity will be assigned to the examining physician or facility. (i.e. if patient is seen in Henrico Health Department and there is no address, the morbidity will be assigned to Henrico Co.).
- **Age:** - Enter the patient's age (provide DOB if applicable).
- **Race:** - Indicate the following: B = Black; W = White, O = Other; Hisp = Hispanic; Asia/PI = Asian/Pacific Islander, AI/AN = American Indian/Alaskan Native.
- **Sex:** - Check appropriate box.
- **Patient Telephone:** - Enter the patient's home telephone number.

Type of Service:

✓ Check the box that best describes the type of health care provider obtaining the culture specimen.

Reason for Exam: ~ (check only one box)

- **Test of Cure (TOC):** - If the laboratory test is taken to determine treatment success or failure (a TOC is recommended 3-7 days after completion of medication).
- **Screening:** - If the physician or medical facility routinely performs gonorrhea cultures on all women who receive a pelvic examination.
- **Diagnosis:** - If the physician or medical facility obtains a laboratory test because he/she suspects the patient of having a gonococcal infection.
- **Contact(GC):** - When the patient is a sex contact to a known case of gonorrhea.

Source of Specimen:

- **Cervix:** - Recommended primary site for obtaining routine gonorrhea culture.
- **Rectum:** - Recommended site for test of cure in females (including cervix); also may be a primary site based upon sexual preference or history.
- **Throat:** - Primary site based upon sexual preference or history.
- **Urethra:** - Primary site for obtaining laboratory test from a male.
- **Other:** - For sites not indicated above.

Report To:

- **Enter the name and address to whom the test results will be returned.**
- **Date Collected** - Enter date specimen was collected.
- **Date Submitted** - Enter date specimen was sent to lab.

0123456789

COMMONWEALTH OF VIRGINIA – DEPARTMENT OF GENERAL SERVICES
DIVISION OF CONSOLIDATED LABORATORY SERVICES
TEST FOR HIV-1 ANTIBODY

NAME_____ _____ _____ DATE COLLECTED _____/_____/_____
(LAST) (FIRST) (M I) MM DD YYYY

SPECIMEN TYPE: O BLOOD O ORAL O OTHER_____ CITY/COUNTY OF RESIDENCE_____

BIRTH DATE	SEX AT BIRTH	RACE	ETHNICITY	MARITAL STATUS	PRE-COUNSELED
_____/_____/_____ MM DD YYYY	O M O F	O WHITE O BLACK O ASIAN O AI/AN O NH/PI O OTHER	O HISPANIC O NON - HISPANIC	O SINGLE O MARRIED O DIVORCED O SEPARATED O WIDOWED	O YES O NO

PREVIOUSLY TESTED FOR HIV ?
O No OYes, Negative OYes, Positive OYes, Inconclusive O Yes, Unknown

SITE TYPE
O STD O ATS O DCJ O FP
O OB O AHC O FIELD O MH
O TB O GMC O CHC O DTC
O OTHER_____

PHYSICIAN _____

PROVIDER NAME _____

ADDRESS _____ COUNSELOR # _____

_____ CLINIC (FIPS) CODE _____

TESTING REASON (MARK ONE)
O VOLUNTEER
O CLIENT REFERRAL
O PROVIDER REFERRAL
O COURT ORDERED
O OCCUPATIONAL EXPOSURE
RETEST
O IMMIGRATION
O COMMUNITY SCREENING
O OTHER_____

SINCE 1978 (MARK ALL THAT APPLY):
O SEX WITH MALE
O SEX WITH FEMALE
O IDU
O SEX WHILE USING NON-INJECTING DRUGS
O SEX FOR DRUGS/MONEY
O STD DIAGNOSIS

ADDITIONAL RISKS:
O NEEDLE SHARING
O HEMOPHILIAC/BLOOD RECIPIENT
O CHILD OF WOMAN WITH HIV/AIDS
O VICTIM OF SEXUAL ASSAULT
O HEALTH CARE EXPOSURE
O MULTIPLE HETEROSEXUAL PARTNERS
O NO ACKNOWLEDGED RISK

SEXUAL RELATIONS WITH:
O IDU
O MAN WHO HAD SEX WITH A MAN
O PERSON WITH HIV/AIDS
O PERSON WITH OTHER HIV/AIDS RISK
O MULTIPLE HETEROSEXUAL PARTNERS
O UNKNOWN

POST-TEST COUNSELED:
O YES O NO
COUNSELOR #_____
DATE: _____/_____/_____
MM DD YYYY

PREVIOUS HIV LAB SLIP #:_____ DATE: _____/_____/_____
(reactive or indeterminant results only) MM DD YYYY

0123456789

TUBE	SENDER RECORDS	HIV LAB DO NOT REMOVE
0_____	0_____	0_____
0_____	0_____	0_____
0_____	0_____	0_____
0_____	0_____	0_____
0_____	0_____	0_____
0_____	0_____	0_____
0_____	0_____	0_____
0_____	0_____	0_____

DO NOT WRITE IN SPACE BELOW
TEST RESULTS

EIA SCREEN
O **NON-REACTIVE (–)**
O **REPEAT REACTIVE (+)**
O **UNSATISFACTORY**

SUPPLEMENTAL WESTERN BLOT TEST
O **NON-REACTIVE (–)**
O **REACTIVE (+)**
(THIS ANTIBODY RESULT IS CONSISTENT WITH HIV-1 INFECTION)
O **INDETERMINANT**
(RESULTS ARE INCONCLUSIVE. SUBMIT ANOTHER SPECIMEN AND INDICATE ON REPORT THAT IT IS A REPEAT)

COMMENTS:_____

DATE RECEIVED: **DATE REPORTED:** **LOCAL, POST-TEST, STATE, LAB**

DEPARTMENT OF GENERAL SERVICES
DIVISION OF CONSOLIDATED LABORATORY SERVICES (DCLS)
&
DEPARTMENT OF HEALTH
DIVISION OF HIV/STD

Test for HIV-1 Antibody Laboratory Slip Instructions

This **laboratory slip** was designed to address the following needs:

1. To provide a standardized and concise format for the collection and recording of epidemiologic information about clients who are tested for HIV antibody.

2. To provide a data collection instrument that allows the evaluation of HIV counseling effectiveness, the prediction of trends, the prevalence of HIV in communities, and facilitates the collection of statistical data for localities, districts, regions, and the state.

The **laboratory slip** is to be completed ***for all clients*** tested for HIV antibody in local health departments, anonymous testing sites and other designated counseling and testing sites. ***It is not intended to replace the Epi-1.*** The Epi-1 should continued to be used to meet the mandatory reporting requirement for HIV morbidity. Additionally, approved counseling forms (Interview Record/Field Record) should be completed for all clients with two reactive ELISA (EIA) tests and a reactive Western blot (WB) by the local health counselors and public health nurses on confidentially tested clients.

Instructions- Write legibly and press down firmly.

1. **Patient Name** - Enter the complete name of the client. Print the complete last and first name of the client, including the middle initial on the space provided. **Anonymous test sites do not need to complete this section.**

2. **Date Collected** - Enter the date (MM/DD/YYYY) of specimen collection.

3. **Specimen Type** - Mark the appropriate box for the type of specimen collected. If the specimen collected is not serum or oral fluid, write the type of specimen collected in the space provided for ***Other***.

4. **City/County of Residence** - Enter the name of the city or the county in which the client resides.

5. **Birth Date** - Enter the client's date (MM/DD/YYYY) of birth. Only the client's age if date of birth is unknown.

6. **Sex at Birth** - Place a check mark in the appropriate box that reflects the client's gender at birth.
   M= Male
   F= Female

7. **Race** - Place a check mark in the appropriate box for the client's race.
   WHITE = A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

   BLACK = A person having origins in any of the black racial groups of Africa.

   ASIAN = A person having origins in any of the original peoples of the Far East, Southeast Asia, or Indian subcontinent.

   AI/AN = American Indian or Alaskan Native - A person having origins in any of the original peoples of North, Central, and South America.

   NH/PI = Native Hawaiian or other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

   Other = A person having origins other than those listed above.

8. **Ethnicity** - Place a check mark in the appropriate box for the client's ethnicity.
   Hispanic = A person of Cuban, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

   Non-Hispanic = A person of a non-Spanish culture or origin.

9. **Marital Status** - Place a check mark in the appropriate box.
   Single = A person who has never been married.
   Married = A person who currently has a legal spouse.
   Divorced = A person whose relationship with a spouse has legally been terminated.
   Separated = A person who is currently married, but no longer a cohabitant with their spouse.
   Widowed = A person whose spouse is deceased.

10. **Pre-Counseled** - Place a check mark in the appropriate box. Check yes if client received HIV prevention counseling. Each client must receive an initial prevention counseling session before being tested.

11. **Previously Tested for HIV?** - Based on the client's record or self report, check one of the following choices that best characterizes the clients experience with HIV testing:
    a. No - Evidence suggests that the client has never tested for HIV before

    b. Yes, Negative - Client history or self-report reflects an HIV negative test result history.

    c. Yes, Positive - Client history or self-report reflects an HIV positive test result history.

    d. Yes, Inclusive - Client history or self-report indicates an inconclusive HIV test result.

    e. Yes, Unknown - Client history or self-report indicates having been HIV tested before, but the client is unsure of their result and the result cannot be verified.

12. **Site Type** - Place a check mark in the appropriate box describing the client's point of service.
    STD = Sexually Transmitted Disease Clinic
    ATS = Anonymous Testing Site
    DCJ = Detention Center, Jail
    FP = Family Planning Clinic
    OB = Obstetrical Clinic
    AHC = Adolescent Health Clinic
    Field = Specimen was Collected off-site
    MH = Maternal Health Clinic
    TB = Tuberculosis Clinic
    GMC = General Medical Clinic
    CHC = Neighborhood/Community Health Clinic
    DTC = Drug Treatment Center

    Other - ***Print one of the following three letter codes on the line provided for any site not listed above:***
    GYN = Gynecological Clinic
    HMS = Homeless Shelter
    MIG = Migrant Clinic
    SHC = Student Health Clinic
    OME = Office of Chief Medical Examiner
    ASO = AIDS Service Organization
    IHI = In Home Intervention
    WPC = Walk in Pregnancy Clinic
    MIL = Military
    PMD = Private Medical Doctor
    SOI = Street Outreach Intervention

    Note - If a site type is not listed in either of the section above, select a category that best reflects the client's reason for visit or the service provided. Use only the codes listed here. Do not make new ones.

13. **Physician/Provider Name and Address** - Enter the name of the clinic/agency/health department/or other provider, complete mailing address, and zip code for the facility, which should receive the test results. If handwritten, please write legibly and press down firmly. If using a pre-printed stamp, please do not obscure any of the other fields. If the pre-printed information obscures the other fields, it makes reading and performing data entry difficult.

14. **Counselor #** - Use one of the following three digit counselor numbers that best describes your work title and enter the three-digit counselor number on the space provided.
    400 - Public health nurses, outreach providers, community based organizations.
    500 - Substance abuse counselors / nurses use
    Health counselor - use assigned worker number

15. **Clinic Code** - Enter the FIPS code for the locality in which the clinic resides or the area where the specimen was collected. (See the attached listing for sites in your district).

16. **Testing Reason** - Check one reason that best describes the client's circumstances for accepting an HIV test. This information will be utilized to determine the effectiveness of our client referral and epidemiologic staff referral of individuals for testing. Please note that this information may vary from that of "Risk Status."

    a. ***Volunteer*** - Client was a walk-in or volunteered for testing.

    b. ***Client Referral*** - Client was tested because their sex and/or IDU partner referred them personally.

c. ***Provider Referral*** - Client was tested or retested because a Health Department Health Counselor, Public Health Nurse, or other HIV Partner Counseling and Referral Services (PCRS) provider informed the client of their potential exposure to HIV or of their positive HIV test and the provider feels there is a need to be tested or retested.

d. ***Court Ordered*** - Client was mandated to be tested by the judicial system.

e. ***Occupational Exposure*** - Client possibly exposed in work setting.

f. ***Retest*** - Client has previously tested for HIV and is requesting an additional test.

g. ***Immigration*** - Client accepted testing because of an immigration physical.

h. ***Community Screening*** - Client accepted testing at an outreach event or health fair.

i. ***Other*** - Please specify any reason for testing not listed above.

17. <u>Since 1978</u> - Mark all assessed risk factors for the client using the following categories. Note there have been some refinements in the definitions of some of the categories to reflect changes made by the Centers for Disease Control and Prevention.

	<u>Mark all that apply</u>
Sex with Male	**Any client who has had sexual relations with a man.**
Sex with Female	**Any client who has had sexual relations with woman.**
IDU	**Any client who has self-injected or received an injection of a non prescription drug or substance.**
Sex While Using Non-Injecting Drugs	**Any client who has had sexual relations while using non-injecting drugs, such as alcohol, crack cocaine or cocaine.**
Sex for Drugs/Money	**Any client who has had sexual relations in exchange for money or drugs.**
STD Diagnosis	**Any client who identifies as having had an STD.**

18. <u>Additional Risks</u> - Mark all of the following additional risks that may have been assessed for the client:

Needle Sharing	**Any client who identifies as having shared drug injecting paraphernalia since 1978.**
Hemophiliac/Blood Recipient	**Any client who has had an injection of whole blood or blood product directly into the blood stream between 1978-1985. Do not include in this category clients whom received immune globulin preparations.**

Child of Woman with HIV/AIDS	**Any child less than 13 years of age whose mother is infected with HIV or has been diagnosed with AIDS.**
Victim of Sexual Assault	**Any client having to perform an act of sexual intimacy without their consent through use, or threat of use of force, or when the client is unable to consent because of a physical or mental disability.**
Health Care Exposure	**Any client who identifies as having been possibly exposed in a health care setting.**
Multiple Heterosexual Partners	**Any client who identifies as having had 10 lifetime heterosexual partners, or three or more heterosexual partners in the previous 12 months.**
No Acknowledged Risk	**Any client whose risk exposure is unknown.**

19. **Sexual Relations With** - Mark all that apply for the client's assessment about their partner(s) risk for exposure. What type(s) of risky behavior(s) does the client's sexual partner(s) have that may put the client at increased risk for HIV infection?

IDU	**Any client who has had sexual relations with an injecting user of a non- prescription drug or substance.**
Man Who Had Sex with a Man	**Any client who has had sexual relations with a man who has had sex with men.**
Person with HIV/AIDS	**Any client who has had sexual relations with a person who has HIV/AIDS.**
Person with Other HIV/AIDS Risk	**This category includes any client who has a partner that does not fall into any of the above risk categories. For example, sex with a blood recipient or sex with a hemophiliac.**
Multiple Heterosexual Partners	**Any client who has had sexual relations with a partner who identifies as having 10 lifetime heterosexual partners, or three or more heterosexual partners in the previous 12 months.**
Unknown	**Any client whose partner's risk behavior is not known.**

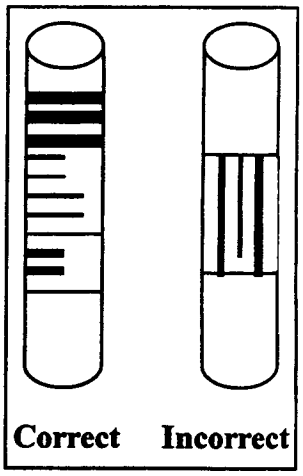
20. **Post-Test Counseled** - Complete this section, regardless of whether results are provided or not. Check yes, if the client received their test result, enter the date (MM/DD/YYYY) of the post-test prevention counseling session, and the counselor number. If the result was not provided on a positive HIV test, check no, and enter the date and counselor number. All positive post-test laboratory slips should be returned to the Division of HIV/STD regardless of whether results were provided to the client.

21. **Previous HIV Laboratory Slip #** - Enter the previous HIV-1 laboratory slip number for any previous test that the client has had in which the test result was indeterminant or positive. Enter the date of the previous test in the space provided. (MM/DD/YYYY)

22. **Barcodes/Computer Labels** - The three barcodes are identical to the unique HIV-1 laboratory number/patient identification number
    a. **Tube** - Remove and place **lengthwise** near the top of the tube. **Do not wrap** the label around the tube; this prevents the use of electronic scanning devices.

    b. **Sender Records** - Local use as deemed necessary for tracking or other purposes.

    c. **HIV Lab** - Do not remove. DCLS use only.



23. **Test Results** - ***DO NOT WRITE IN THIS AREA.*** THIS SPACE WILL BE COMPLETED BY THE DCLS LABORATORY TECHNICIAN.

EIA SCREEN

NON-REACTIVE - Negative antibody test result

REPEAT REACTIVE - Two positive antibody EIA screening tests. (Sample will automatically be tested using the confirmatory Western Blot)

UNSATISFACTORY - The test result for this specimen is irreproducible, the quantity of fluid is not sufficient (QNS), the specimen was hemolyzed, or otherwise not fit to test.

SUPPLEMENTAL WESTERN BLOT TEST (CONFIRMATORY TEST)

NON-REACTIVE - The WB was negative.

REACTIVE - This antibody result is consistent with HIV-1 infection.

INDETERMINATE - The results are inconclusive. Submit another specimen and indicate on report that it is a repeat.

24. **Date Received** - The date the laboratory received the specimen for processing.

25. **Date Report** - The date the laboratory performed the test.

Laboratory Slip Distribution - Send the entire completed HIV-1 laboratory slip to DCLS with the specimen. The barcode marked "Sender Records" can be removed by the collection site for tracking purposes. After the specimen is processed at DCLS, copies of the laboratory slip will be distributed as follows:

First Copy **(Local)** - Returned to the testing site and retained on file according to local protocol.

Second Copy **(Post-Test)** - Returned to the testing site. Any non-completed data sets should be completed and post-test counseling data is added, as appropriate. When the post-test counseling occurs or after *60* days, this copy is forwarded to the Division of HIV/STD for database update.

Third Copy **(State)** - Forwarded by DCLS to the Division of HIV/STD for data entry.

Fourth Copy **(Lab)** - Retained on file at DCLS.

Data Report Distribution -

- A report of HIV-1 testing and counseling by clinic type is generated and sent out quarterly.
- A report of HIV-1 testing and counseling by demographics is generated and sent out twice a year.
- Special ad hoc reports can be generated from the database. However, certain limitations may apply. Sufficient time should be allotted for requests of such reports.

1B 1A

5936-0622-1225 Moore ® 225

COMMONWEALTH OF VIRGINIA – DEPARTMENT OF GENERAL SERVICES

DIVISION OF CONSOLIDATED LABORATORY SERVICES

TEST FOR HIV–1 ANTIBODY

NAME _____ (LAST) _____ (FIRST) ____ (M I) DATE COLLECTED ____/____/____ MM DD YYYY

SPECIMEN TYPE: O BLOOD O ORAL O OTHER _____ CITY/COUNTY OF RESIDENCE _____

BIRTH DATE	SEX	RACE	ETHNICITY	MARITAL STATUS	PRE-COUNSELED
____/____/____ MM DD YYYY	O M O F	O WHITE O BLACK O ASIAN O AI/AN O NH/PI O OTHER	O HISPANIC O NON - HISPANIC	O SINGLE O MARRIED O DIVORCED O SEPARATED O WIDOWED	O YES O NO

PREVIOUSLY TESTED FOR HIV?
O No O Yes, Negative O Yes, Positive O Yes, Inconclusive O Yes, Unknown

SITE TYPE
O STD O ATS O DCJ O FP
O OB O AHC O FIELD O MH
O TB O GMC O CHC O DTC
O OTHER _____

PHYSICIAN _____

PROVIDER NAME _____

ADDRESS _____

_____

COUNSELOR # _____

CLINIC (FIPS) CODE _____

TESTING REASON (MARK ONE)
- O VOLUNTEER
- O CLIENT REFERRAL
- O PROVIDER REFERRAL
- O COURT ORDERED
- O OCCUPATIONAL EXPOSURE
- O RETEST
- O IMMIGRATION
- O COMMUNITY SCREENING
- O OTHER _____

SINCE 1978 (MARK ALL THAT APPLY):
- O SEX WITH MALE
- O SEX WITH FEMALE
- O IDU
- O SEX WHILE USING NON-INJECTING DRUGS
- O SEX FOR DRUGS/MONEY
- O STD DIAGNOSIS

ADDITIONAL RISKS:
- O NEEDLE SHARING
- O HEMOPHILIAC/BLOOD RECIPIENT
- O CHILD OF WOMAN WITH HIV/AIDS
- O VICTIM OF SEXUAL ASSAULT
- O HEALTH CARE EXPOSURE
- O MULTIPLE HETEROSEXUAL PARTNERS
- O NO ACKNOWLEDGED RISK

SEXUAL RELATIONS WITH:
- O IDU
- O MAN WHO HAD SEX WITH A MAN
- O PERSON WITH HIV/AIDS
- O PERSON WITH OTHER HIV/AIDS RISK
- O MULTIPLE HETEROSEXUAL PARTNERS
- O UNKNOWN

POST-TEST COUNSELED
O YES O NO
COUNSELOR _____
DATE ____/____/____ MM DD YYYY

1292651

PREVIOUS HIV LAB SLIP # _____ (reactive or indeterminant results only) DATE: ____/____/____ MM DD YYYY

SPECIMEN TUBE | SENDER RECORDS | HIV LAB (DO NOT REMOVE)

DO NOT WRITE IN SPACE BELOW

TEST RESULTS

EIA SCREEN	SUPPLEMENTAL WESTERN BLOT TEST
O NON-REACTIVE (-)	O NON-REACTIVE(-)
O REPEAT REACTIVE (+)	O REACTIVE(+) (THIS ANTIBODY RESULT IS CONSISTENT WITH HIV-1 INFECTION).
O UNSATISFACTORY	O INDETERMINANT (RESULTS ARE INCONCLUSIVE.SUBMIT ANOTHER SPECIMEN AND INDICATE ON REPORT THAT IT IS A REPEAT.)

COMMENTS _____

DATE REPORTED:

DATE RECEIVED:

DGS–22–189 (Rev. 7/01)

LOCAL

COMMONWEALTH of VIRGINIA

Department of Health
P O BOX 2448
RICHMOND, VA 23218

TDD 1-800-828-1120

Donald R. Stern, M.D., M.P.H.
Acting State Health Commissioner

MEMORANDUM

DATE: February 8, 1995

TO: STD/AIDS Program Supervisors

FROM: Casey W. Riley, Director
Bureau of STD/AIDS

SUBJECT: HIV-1 Laboratory Slips

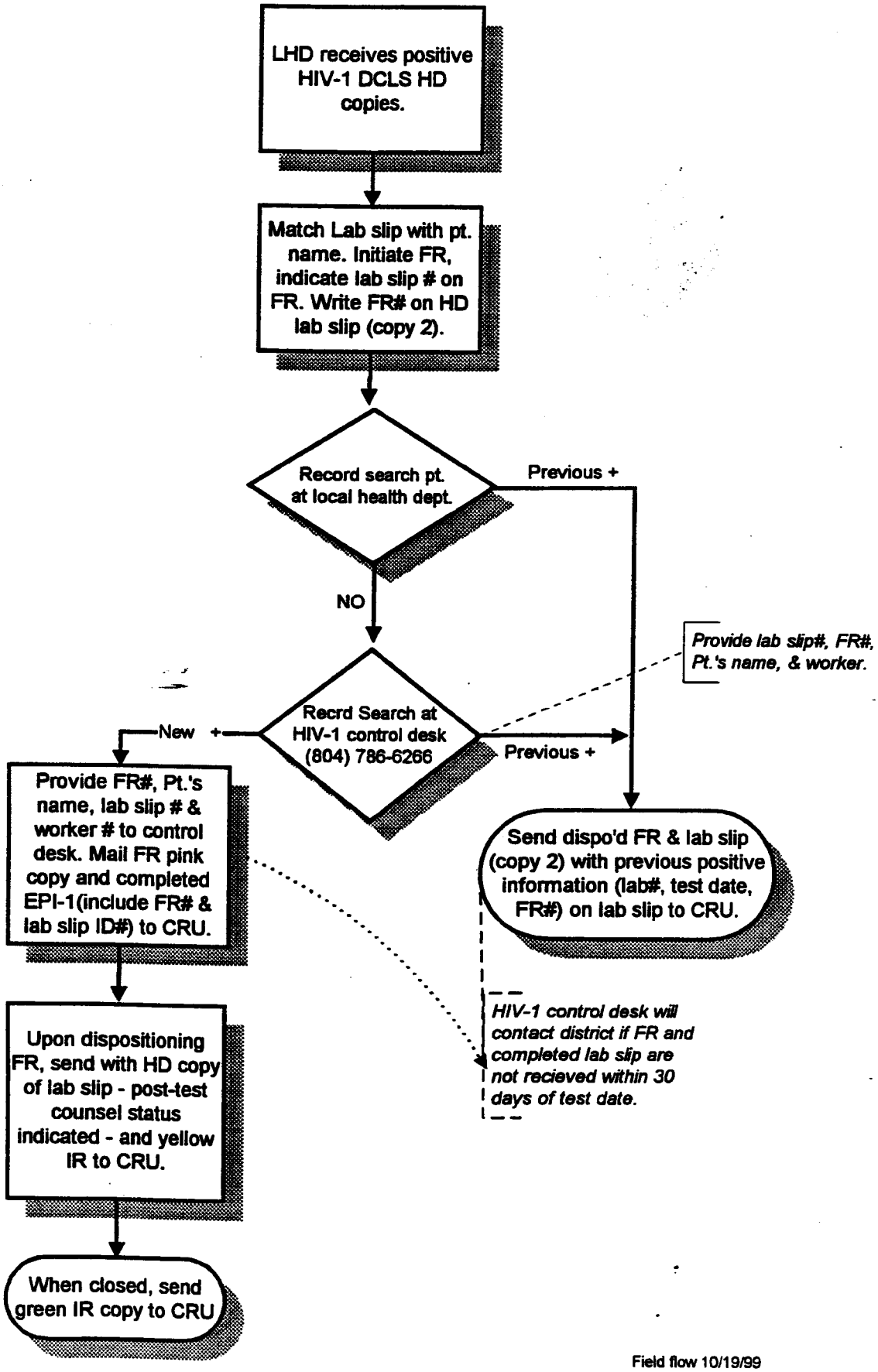
Recently, issues surrounding post-test counseling as it relates to completion and routing of the laboratory form has become a concern. The procedure for disposition of the HIV-1 laboratory slip has not changed:

1. The carbon HEALTH DEPT copy of the laboratory slip is to be sent to the field operations office on a weekly or bi-weekly basis for patients post-test counseled.

2. You need to generate and review with local health department personnel quarterly counseling and testing reports and identify, if appropriate, the reason(s) for low return rates. Low percentages of patients post-test counseled may be an indication that persons are not returning for their test results and/or HIV-1 laboratory slips are not being received by the field operations office for data entry.

CWR/dje

Positive HIV-1 Confidential DCLS Report



Field flow 10/19/99

0123456789

COMMONWEALTH OF VIRGINIA – DEPARTMENT OF GENERAL SERVICES
DIVISION OF CONSOLIDATED LABORATORY SERVICES
TEST FOR HIV-1 ANTIBODY

NAME_____ _____ _____ DATE COLLECTED _____/_____/_____
(LAST) (FIRST) (M I) MM DD YYYY

SPECIMEN TYPE: O BLOOD O ORAL O OTHER_____ CITY/COUNTY OF RESIDENCE_____

BIRTH DATE	SEX AT BIRTH	RACE	ETHNICITY	MARITAL STATUS	PRE-COUNSELED
_____/_____/_____ MM DD YYYY	O M O F	O WHITE O BLACK O ASIAN O AI/AN O NH/PI O OTHER	O HISPANIC O NON - HISPANIC	O SINGLE O MARRIED O DIVORCED O SEPARATED O WIDOWED	O YES O NO

PREVIOUSLY TESTED FOR HIV ?
O No OYes, Negative OYes, Positive OYes, Inconclusive O Yes, Unknown

SITE TYPE
O STD O ATS O DCJ O FP
O OB O AHC O FIELD O MH
O TB O GMC O CHC O DTC
O OTHER_____

PHYSICIAN _____

PROVIDER NAME _____

ADDRESS _____ COUNSELOR # _____

_____ CLINIC (FIPS) CODE _____

TESTING REASON (MARK ONE)
O VOLUNTEER
O CLIENT REFERRAL
O PROVIDER REFERRAL
O COURT ORDERED
O OCCUPATIONAL EXPOSURE
O RETEST
O IMMIGRATION
O COMMUNITY SCREENING
O OTHER_____

SINCE 1978 (MARK ALL THAT APPLY):
O SEX WITH MALE
O SEX WITH FEMALE
O IDU
O SEX WHILE USING NON-INJECTING DRUGS
O SEX FOR DRUGS/MONEY
O STD DIAGNOSIS

ADDITIONAL RISKS:
O NEEDLE SHARING
O HEMOPHILIAC/BLOOD RECIPIENT
O CHILD OF WOMAN WITH HIV/AIDS
O VICTIM OF SEXUAL ASSAULT
O HEALTH CARE EXPOSURE
O MULTIPLE HETEROSEXUAL PARTNERS
O NO ACKNOWLEDGED RISK

SEXUAL RELATIONS WITH:
O IDU
O MAN WHO HAD SEX WITH A MAN
O PERSON WITH HIV/AIDS
O PERSON WITH OTHER HIV/AIDS RISK
O MULTIPLE HETEROSEXUAL PARTNERS
O UNKNOWN

POST-TEST COUNSELED:
O YES O NO
COUNSELOR # _____
DATE: _____/_____/_____
MM DD YYYY

PREVIOUS HIV LAB SLIP #:_____ DATE: _____/_____/_____
(reactive or indeterminant results only) MM DD YYYY

0123456789

TUBE	SENDER RECORDS	HIV LAB DO NOT REMOVE
0_____	0_____	0_____
0_____	0_____	0_____
0_____	0_____	0_____
0_____	0_____	0_____
0_____	0_____	0_____
0_____	0_____	0_____
0_____	0_____	0_____
0_____	0_____	0_____

DO NOT WRITE IN SPACE BELOW
TEST RESULTS

EIA SCREEN
O **NON-REACTIVE (--)**
O **REPEAT REACTIVE (+)**
O **UNSATISFACTORY**

SUPPLEMENTAL WESTERN BLOT TEST
O **NON-REACTIVE (--)**
O **REACTIVE (+)**
(THIS ANTIBODY RESULT IS CONSISTENT WITH HIV-1 INFECTION)
O **INDETERMINANT**
(RESULTS ARE INCONCLUSIVE. SUBMIT ANOTHER SPECIMEN AND INDICATE ON REPORT THAT IT IS A REPEAT)

COMMENTS:_____

DATE RECEIVED: **DATE REPORTED:** **LOCAL, POST-TEST, STATE, LAB**

DEPARTMENT OF GENERAL SERVICES
DIVISION OF CONSOLIDATED LABORATORY SERVICES (DCLS)
&
DEPARTMENT OF HEALTH
DIVISION OF HIV/STD

Test for HIV-1 Antibody Laboratory Slip Instructions

This **laboratory slip** was designed to address the following needs:

1. To provide a standardized and concise format for the collection and recording of epidemiologic information about clients who are tested for HIV antibody.

2. To provide a data collection instrument that allows the evaluation of HIV counseling effectiveness, the prediction of trends, the prevalence of HIV in communities, and facilitates the collection of statistical data for localities, districts, regions, and the state.

The **laboratory slip** is to be completed ***for all clients*** tested for HIV antibody in local health departments, anonymous testing sites and other designated counseling and testing sites. ***It is not intended to replace the Epi-1.*** The Epi-1 should continued to be used to meet the mandatory reporting requirement for HIV morbidity. Additionally, approved counseling forms (Interview Record/Field Record) should be completed for all clients with two reactive ELISA (EIA) tests and a reactive Western blot (WB) by the local health counselors and public health nurses on confidentially tested clients.

Instructions- Write legibly and press down firmly.

1. **Patient Name** - Enter the complete name of the client. Print the complete last and first name of the client, including the middle initial on the space provided. **Anonymous test sites do not need to complete this section.**

2. **Date Collected** - Enter the date (MM/DD/YYYY) of specimen collection.

3. **Specimen Type** - Mark the appropriate box for the type of specimen collected. If the specimen collected is not serum or oral fluid, write the type of specimen collected in the space provided for ***Other***.

4. **City/County of Residence** - Enter the name of the city or the county in which the client resides.

5. **Birth Date** - Enter the client's date (MM/DD/YYYY) of birth. Only the client's age if date of birth is unknown.

6. **Sex at Birth** - Place a check mark in the appropriate box that reflects the client's gender at birth.
   M= Male
   F= Female

7. **Race** - Place a check mark in the appropriate box for the client's race.
   WHITE = A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

   BLACK = A person having origins in any of the black racial groups of Africa.

   ASIAN = A person having origins in any of the original peoples of the Far East, Southeast Asia, or Indian subcontinent.

   AI/AN = American Indian or Alaskan Native - A person having origins in any of the original peoples of North, Central, and South America.

   NH/PI = Native Hawaiian or other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

   Other = A person having origins other than those listed above.

8. **Ethnicity** - Place a check mark in the appropriate box for the client's ethnicity.
   Hispanic = A person of Cuban, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

   Non-Hispanic = A person of a non-Spanish culture or origin.

9. **Marital Status** - Place a check mark in the appropriate box.
   Single = A person who has never been married.
   Married = A person who currently has a legal spouse.
   Divorced = A person whose relationship with a spouse has legally been terminated.
   Separated = A person who is currently married, but no longer a cohabitant with their spouse.
   Widowed = A person whose spouse is deceased.

10. **Pre-Counseled -** Place a check mark in the appropriate box. Check yes if client received HIV prevention counseling. Each client must receive an initial prevention counseling session before being tested.

11. **Previously Tested for HIV?** - Based on the client's record or self report, check one of the following choices that best characterizes the clients experience with HIV testing:
    a. No - Evidence suggests that the client has never tested for HIV before

    b. Yes, Negative - Client history or self-report reflects an HIV negative test result history.

    c. Yes, Positive - Client history or self-report reflects an HIV positive test result history.

    d. Yes, Inclusive - Client history or self-report indicates an inconclusive HIV test result.

    e. Yes, Unknown - Client history or self-report indicates having been HIV tested before, but the client is unsure of their result and the result cannot be verified.

12. **Site Type -** Place a check mark in the appropriate box describing the client's point of service.

STD = Sexually Transmitted Disease Clinic
ATS = Anonymous Testing Site
DCJ = Detention Center, Jail
FP = Family Planning Clinic
OB = Obstetrical Clinic
AHC = Adolescent Health Clinic
Field = Specimen was Collected off-site
MH = Maternal Health Clinic
TB = Tuberculosis Clinic
GMC = General Medical Clinic
CHC = Neighborhood/Community Health Clinic
DTC = Drug Treatment Center

Other - ***Print one of the following three letter codes on the line provided for any site not listed above:***

GYN = Gynecological Clinic
HMS = Homeless Shelter
MIG = Migrant Clinic
SHC = Student Health Clinic
OME = Office of Chief Medical Examiner
ASO = AIDS Service Organization
IHI = In Home Intervention
WPC = Walk in Pregnancy Clinic
MIL = Military
PMD = Private Medical Doctor
SOI = Street Outreach Intervention

Note - If a site type is not listed in either of the section above, select a category that best reflects the client's reason for visit or the service provided. Use only the codes listed here. Do not make new ones.

13. **Physician/Provider Name and Address** - Enter the name of the clinic/agency/health department/or other provider, complete mailing address, and zip code for the facility, which should receive the test results. If handwritten, please write legibly and press down firmly. If using a pre-printed stamp, please do not obscure any of the other fields. If the pre-printed information obscures the other fields, it makes reading and performing data entry difficult.

14. **Counselor #** - Use one of the following three digit counselor numbers that best describes your work title and enter the three-digit counselor number on the space provided.

400 - Public health nurses, outreach providers, community based organizations.
500 - Substance abuse counselors / nurses use
Health counselor - use assigned worker number

15. **Clinic Code -** Enter the FIPS code for the locality in which the clinic resides or the area where the specimen was collected. (See the attached listing for sites in your district).

16. **Testing Reason** - Check one reason that best describes the client's circumstances for accepting an HIV test. This information will be utilized to determine the effectiveness of our client referral and epidemiologic staff referral of individuals for testing. Please note that this information may vary from that of "Risk Status."

a. ***Volunteer*** - Client was a walk-in or volunteered for testing.

b. ***Client Referral -*** Client was tested because their sex and/or IDU partner referred them personally.

c. ***Provider Referral*** **-** Client was tested or retested because a Health Department Health Counselor, Public Health Nurse, or other HIV Partner Counseling and Referral Services (PCRS) provider informed the client of their potential exposure to HIV or of their positive HIV test and the provider feels there is a need to be tested or retested.

d. ***Court Ordered*** - Client was mandated to be tested by the judicial system.

e. ***Occupational Exposure*** - Client possibly exposed in work setting.

f. ***Retest*** - Client has previously tested for HIV and is requesting an additional test.

g. ***Immigration*** - Client accepted testing because of an immigration physical.

h. ***Community Screening*** - Client accepted testing at an outreach event or health fair.

i. ***Other*** - Please specify any reason for testing not listed above.

17. **Since 1978** - Mark all assessed risk factors for the client using the following categories. Note there have been some refinements in the definitions of some of the categories to reflect changes made by the Centers for Disease Control and Prevention.

	Mark all that apply
Sex with Male	**Any client who has had sexual relations with a man.**
Sex with Female	**Any client who has had sexual relations with woman.**
IDU	**Any client who has self-injected or received an injection of a non prescription drug or substance.**
Sex While Using Non-Injecting Drugs	**Any client who has had sexual relations while using non-injecting drugs, such as alcohol, crack cocaine or cocaine.**
Sex for Drugs/Money	**Any client who has had sexual relations in exchange for money or drugs.**
STD Diagnosis	**Any client who identifies as having had an STD.**

18. **Additional Risks** - Mark all of the following additional risks that may have been assessed for the client:

Needle Sharing	**Any client who identifies as having shared drug injecting paraphernalia since 1978.**
Hemophiliac/Blood Recipient	**Any client who has had an injection of whole blood or blood product directly into the blood stream between 1978-1985. Do not include in this category clients whom received immune globulin preparations.**

Child of Woman with HIV/AIDS	**Any child less than 13 years of age whose mother is infected with HIV or has been diagnosed with AIDS.**
Victim of Sexual Assault	**Any client having to perform an act of sexual intimacy without their consent through use, or threat of use of force, or when the client is unable to consent because of a physical or mental disability.**
Health Care Exposure	**Any client who identifies as having been possibly exposed in a health care setting.**
Multiple Heterosexual Partners	**Any client who identifies as having had 10 lifetime heterosexual partners, or three or more heterosexual partners in the previous 12 months.**
No Acknowledged Risk	**Any client whose risk exposure is unknown.**

19. **Sexual Relations With -** Mark all that apply for the client's assessment about their partner(s) risk for exposure. What type(s) of risky behavior(s) does the client's sexual partner(s) have that may put the client at increased risk for HIV infection?

IDU	**Any client who has had sexual relations with an injecting user of a non- prescription drug or substance.**
Man Who Had Sex with a Man	**Any client who has had sexual relations with a man who has had sex with men.**
Person with HIV/AIDS	**Any client who has had sexual relations with a person who has HIV/AIDS.**
Person with Other HIV/AIDS Risk	**This category includes any client who has a partner that does not fall into any of the above risk categories. For example, sex with a blood recipient or sex with a hemophiliac.**
Multiple Heterosexual Partners	**Any client who has had sexual relations with a partner who identifies as having 10 lifetime heterosexual partners, or three or more heterosexual partners in the previous 12 months.**
Unknown	**Any client whose partner's risk behavior is not known.**

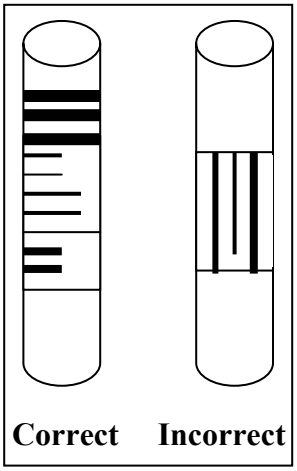
20. **Post-Test Counseled -** Complete this section, regardless of whether results are provided or not. Check yes, if the client received their test result, enter the date (MM/DD/YYYY) of the post-test prevention counseling session, and the counselor number. If the result was not provided on a positive HIV test, check no, and enter the date and counselor number. All positive post-test laboratory slips should be returned to the Division of HIV/STD regardless of whether results were provided to the client.

21. **Previous HIV Laboratory Slip # -** Enter the previous HIV-1 laboratory slip number for any previous test that the client has had in which the test result was indeterminant or positive. Enter the date of the previous test in the space provided. (MM/DD/YYYY)

22. **Barcodes/Computer Labels** - The three barcodes are identical to the unique HIV-1 laboratory number/patient identification number
    a. **Tube** - Remove and place **lengthwise** near the top of the tube. **Do not wrap** the label around the tube; this prevents the use of electronic scanning devices.

    b. **Sender Records -** Local use as deemed necessary for tracking or other purposes.

    c. **HIV Lab** - Do not remove. DCLS use only.



23. **Test Results** - ***DO NOT WRITE IN THIS AREA***. THIS SPACE WILL BE COMPLETED BY THE DCLS LABORATORY TECHNICIAN .

EIA SCREEN

NON-REACTIVE - Negative antibody test result

REPEAT REACTIVE - Two positive antibody EIA screening tests. (Sample will automatically be tested using the confirmatory Western Blot)

UNSATISFACTORY - The test result for this specimen is irreproducible, the quantity of fluid is not sufficient (QNS), the specimen was hemolyzed, or otherwise not fit to test**.**

SUPPLEMENTAL WESTERN BLOT TEST (CONFIRMATORY TEST)

NON-REACTIVE - The WB was negative.

REACTIVE - This antibody result is consistent with HIV-1 infection.

INDETERMINATE - The results are inconclusive. Submit another specimen and indicate on report that it is a repeat.

24. **Date Received -** The date the laboratory received the specimen for processing.

25. **Date Report -** The date the laboratory performed the test**.**

Laboratory Slip Distribution - Send the entire completed HIV-1 laboratory slip to DCLS with the specimen. The barcode marked "Sender Records" can be removed by the collection site for tracking purposes. After the specimen is processed at DCLS, copies of the laboratory slip will be distributed as follows:

First Copy **(Local)** - Returned to the testing site and retained on file according to local protocol.

Second Copy **(Post-Test) -** Returned to the testing site. Any non-completed data sets should be completed and post-test counseling data is added, as appropriate. When the post-test counseling occurs or after *60* days, this copy is forwarded to the Division of HIV/STD for database update.

Third Copy **(State) -** Forwarded by DCLS to the Division of HIV/STD for data entry.

Fourth Copy **(Lab) -** Retained on file at DCLS.

Data Report Distribution -

- A report of HIV-1 testing and counseling by clinic type is generated and sent out quarterly.
- A report of HIV-1 testing and counseling by demographics is generated and sent out twice a year.
- Special ad hoc reports can be generated from the database. However, certain limitations may apply. Sufficient time should be allotted for requests of such reports.

COMMONWEALTH of VIRGINIA

C. M. G. BUTTERY, M.D., M.P.H.
STATE HEALTH COMMISSIONER

Department of Health
P. O. BOX 2448
RICHMOND, VA 23218

DATE: December 6, 1991

TO: Regional Directors
District Directors
at Headquarters and Branch Offices

THROUGH: Robert B. Stroube, M.D., M.P.H.
Deputy Commissioner for Community Health Services

Grayson B. Miller, Jr., M.D.
Acting Deputy Commissioner for Health Care Services

FROM: A. Martin Cader, M.D., Director
Division of Communicable Disease Control

James W. Blaine, Ph.D., Assistant Director
Bureau of Microbiology
Division of Consolidated Laboratory Services

SUBJECT: Amendment #21 to AIDS/HIV Program Operations Manual/Revised Serological Test For HIV-1 Antibody Laboratory Form

The Division of Consolidated Laboratory Services (DCLS) has revised the **Serological Test For HIV-1 Antibody Laboratory Form** (Form # DGS-22-189). This form enhances the tracking of test results and the collection of demographic and epidemiologic information. It will obviate the need to gather such information from the HIV counseling form.

Please utilize the new form when your supply of the current form is depleted. Instructions for completion and routing of the new form are enclosed. Early in 1992, regional office personnel will begin entering data collected on the form into an electronic information system. You will be notified when this system is operational. Until then, please continue to submit HIV counseling and testing data monthly. If you have questions, please call Richard L. Bradley at (804) 786-6267.

Please place this memo in Part I, Section 2 of the AIDS Operations Manual.

AMC/JWB/dje

Enclosure

COMMONWEALTH OF VIRGINIA – DEPARTMENT OF GENERAL SERVICES
DIVISION OF CONSOLIDATED LABORATORY SERVICES – BUREAU OF MICROBIOLOGICAL SCIENCES
SEROLOGICAL TEST FOR HIV–1 ANTIBODY

BIRTH DATE	SEX	RACE	MARITAL STATUS	PRE–COUNSELED
/ /	( ) M ( ) F	( ) WHITE ( ) BLACK ( ) HISP ( ) ASIA/PI ( ) AI/AN ( ) OT/UNK	( ) S ( ) M ( ) D ( ) SEP	( ) YES ( ) NO

COUNSELOR #:_____
CLINIC CODE:_____
REGION #:_____

CLINIC TYPE:
( ) STD ( ) DTC
( ) ATS ( ) MH
( ) TB ( ) FP
( ) OB ( ) PMD_____
( ) MIL ( ) OTHER_____

TESTING REASON:
( ) VOL
( ) PARTNER REFERRAL
( ) PROVIDER REFERRAL
( ) OTHER (specify)
_____

RISK STATUS:
( ) GAY/BI ( ) PED
( ) GAY/IV ( ) HEMO
( ) GAY/TA ( ) HET CT HIV/HI RISK
( ) IV ( ) MULT HET CTS
( ) TA ( ) NONE/UNK

CONTACT INFORMATION:
( ) FEMALE S/P OF BISEXUAL MALE
( ) S/P OF PERSON WITH AIDS/HIV
( ) S/P OF IVDU
( ) S/P AND N/S OF IVDU
( ) N/S OF IVDU
( ) S/P OF HEMOPHILIAC/BLOOD REC.
( ) EXCHANGE MONEY/DRUGS FOR SEX
( ) OTHER _____
( ) NONE

DATE COLLECTED: / /

PATIENT IDENTIFICATION:

293588

SPECIMEN TUBE 293588
SENDER RECORDS 293588
HIV LAB (DO NOT REMOVE) 293588

REPORT TO:
PHYSICIAN_____
HEALTH DEPARTMENT_____
ADDRESS_____
CITY_____ VA_____ ZIP CODE

POST–COUNSELED: ( ) YES ( ) NO DATE / / COUNSELOR #:_____

PREVIOUS HIV LAB #_____ DATE / /
(REACTIVES OR INDETERMINANTS ONLY)

DO NOT WRITE IN SPACE BELOW

TEST RESULTS

EIA SCREEN	SUPPLEMENTAL WESTERN BLOT TEST
( ) NON–REACTIVE	( ) NON–REACTIVE
( ) REPEAT REACTIVE	( ) REACTIVE (THIS ANTIBODY RESULT IS CONSISTENT WITH HIV-1 INFECTION).
	( ) INDETERMINANT (RESULTS ARE INCONCLUSIVE. SUBMIT ANOTHER SPECIMEN AND INDICATE ON REPORT THAT IT IS A REPEAT).

UNSATISFACTORY: _____

DATE RECEIVED: DATE REPORTED: HIV LAB NUMBER:_____

DGS–22–189 (Rev. 11/91)

HEALTH DEPARTMENT

LOCAL USE ONLY

Mother's Name: _____ Chart No.: _____

Address: _____ (Number, Street, City, State) _____ (Zip Code) Phone No.: ( ) _____

Infant's Name: _____ Chart No.: _____ Delivering Physician: _____ Phone No.: ( ) _____

Pediatrician: _____ Phone No.: ( ) _____ – *Patient identifier information is not transmitted to CDC* –

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention
Atlanta, GA 30333

CONGENITAL SYPHILIS (CS) CASE INVESTIGATION AND REPORT

CASE ID No.: (1-7) 021696

Form Approved OMB No. 0920-0128 Exp. 05/94

Local Use ID No.: _____

PART I. REPORTING INFORMATION

1. Report date to health dept. ☐ Unk — ___/___/___ Mo. Day Yr. (8-13)

2. Reporting state FIPS code: ☐ Unk — ___ (14-15) Reporting State Name

3. Reporting county FIPS code: ☐ Unk — ___ (16-18) Reporting County Name

4. Reporting city FIPS code: ☐ Unk — ___ (19-22) Reporting City Name

5. Other geographic unit (optional): ___ (23-25)

6. Sentinel reporting site: (26) 1 ☐ Yes 2 ☐ No

PART II. MATERNAL INFORMATION

7. State FIPS code: ☐ Unk — ___ (27-28) Residence State Name

8. Residence county FIPS code: ☐ Unk — ___ (29-31) Residence County Name

9. Residence city FIPS code: ☐ Unk — ___ (32-35) Residence City Name

10. Residence zip code: ☐ Unk — ___ (36-40)

11. Mother's date of birth: ☐ Unk — ___/___/___ Mo. Day Yr. (41-46)

12. Mother's race: (47) 1 ☐ White 2 ☐ Black 3 ☐ American Indian/Alaskan Native 4 ☐ Asian/Pacific Islander 8 ☐ Other 9 ☐ Unk

13. Mother's ethnicity: (48) 1 ☐ Hispanic 2 ☐ Non-Hispanic 9 ☐ Unk

14. Mother's marital status: (49) 1 ☐ Single, never married 2 ☐ Married 3 ☐ Separated/Divorced 4 ☐ Widow 8 ☐ Other 9 ☐ Unk

15. Last menstrual period (LMP) (before delivery) ☐ Unk — ___/___/___ Mo. Day Yr. (50-55)

16. Did mother have prenatal care? (56) 1 ☐ Yes 2 ☐ No *(Go to Q19)* 9 ☐ Unk *(Go to Q19)*

17. Indicate date of first prenatal visit: ☐ Unk — ___/___/___ Mo. Day Yr. (57-62)

18. Indicate number of prenatal visits: ☐ Unk — ___ (63-64)

19. Did mother have a nontreponemal test (e.g., RPR or VDRL) in pregnancy, at delivery, or soon after delivery? (65) 1 ☐ Yes 2 ☐ No *(Go to Q22)* 9 ☐ Unk *(Go to Q22)*

20. Indicate dates and results of nontreponemal tests:

	Date (Mo. Day Yr.)		Results	
a.	___/___/___ (66-71)	☐ Unk	1 ☐ Reactive 2 ☐ Nonreactive 9 ☐ Unk (72)	
b.	___/___/___ (73-78)	☐ Unk	1 ☐ Reactive 2 ☐ Nonreactive 9 ☐ Unk (79)	
c.	___/___/___ (80-85)	☐ Unk	1 ☐ Reactive 2 ☐ Nonreactive 9 ☐ Unk (86)	
d.	___/___/___ (87-92)	☐ Unk	1 ☐ Reactive 2 ☐ Nonreactive 9 ☐ Unk (93)	

21. Indicate titer of nontreponemal test closest to delivery: ☐ Unk — 1: ___ (94-97)

22. Did mother have confirmatory treponemal test result (e.g., FTA-ABS or MHATP)? (98) (Footnote a) 1 ☐ Yes, reactive 2 ☐ Yes, nonreactive 3 ☐ No test 9 ☐ Unknown

23. Did mother have darkfield or direct fluorescent antibody (DFA) exam of lesions at delivery? (99) (Footnote a) 1 ☐ Yes, positive 2 ☐ Yes, negative 3 ☐ No test 9 ☐ Unknown

24. When was mother last treated for syphilis? (100) 1 ☐ Before pregnancy *(Go to Q25)* 2 ☐ During Pregnancy *(Go to Q26)* 3 ☐ No Treatment *(Go to Q28)* 9 ☐ Unknown *(Go to Q28)*

25. Before pregnancy, was mother's treatment adequate? (101) (Footnote b) 1 ☐ Yes, adequate *(Go to Q27)* 2 ☐ No, inadequate *(Go to Q28)* 9 ☐ Unknown *(Go to Q28)*

26. During pregnancy, was mother's treatment adequate? (102) (Footnote b) 1 ☐ Yes, adequate 2 ☐ No, inadequate: non-penicillin therapy *(Go to Q28)* 3 ☐ No, inadequate: penicillin therapy begun < 30 days before delivery *(Go to Q28)* 4 ☐ Unknown *(Go to Q28)*

27. An appropriate serologic response? (103) (Footnote c) 1 ☐ Yes, appropriate response with adequate serologic follow-up during pregnancy 2 ☐ Yes, appropriate response but no follow-up serologic titers during pregnancy 3 ☐ No, inappropriate response: evidence of treatment failure or reinfection 4 ☐ No, response was equivocal or could not be determined from available nontreponemal titer information

PART III. INFANT INFORMATION

28. Date of Delivery: ☐ Unk — ___/___/___ Mo. Day Yr. (104-109)

29. Vital status: (110) 1 ☐ Alive *(Go to Q31)* 2 ☐ Born alive, then died 3 ☐ Stillborn *(Go to Q32)* (Footnote d) 9 ☐ Unk *(Go to Q31)*

30. Indicate date of death ☐ Unk — ___/___/___ Mo. Day Yr. (111-116)

31. Gender: (117) 1 ☐ Male 2 ☐ Female 9 ☐ Unk

32. Birthweight (in grams) ☐ Unk — ___ (118-121)

33. Estimated gestational age (in weeks) ☐ Unk — ___ (122-123) *(If infant was stillborn go to Q44)*

34. Did infant/child have a reactive serologic test for syphilis (e.g., RPR, VDRL, FTA-ABS or MHA-TP) ? (124) 1 ☐ Yes 2 ☐ No *(Go to Q36)* 9 ☐ Unk *(Go to Q36)*

35. When was the infant/child's first reactive serologic test for syphilis? ☐ Unk — ___/___/___ Mo. Day Yr. (125-130)

36. Did the infant/child have any classic signs of CS? (131) (Footnote e) 1 ☐ Yes 2 ☐ No, asymptomatic infant/child 9 ☐ Unk

Laboratory Confirmation

37. Did the infant/child have a darkfield exam? (132) 1 ☐ Yes, positive 2 ☐ Yes, negative 3 ☐ No test 9 ☐ Unk.

38. Did the infant/child have a direct fluorescent antibody test? (133) 1 ☐ Yes, positive 2 ☐ Yes, negative 3 ☐ No test 9 ☐ Unk.

39. Did the infant/child have an IgM-specific treponemal test? (134) (Footnote f) 1 ☐ Yes, reactive 2 ☐ Yes, nonreactive 3 ☐ No test 9 ☐ Unk.

Infant/Child Evaluation

40. Did the infant/child have long bone X-rays? (135) 1 ☐ Yes, changes consistent with CS 2 ☐ Yes, no signs of CS 3 ☐ No xrays 9 ☐ Unk.

41. Did the infant/child have a CSF-VDRL? (136) 1 ☐ Yes, reactive 2 ☐ Yes, nonreactive 3 ☐ No test 9 ☐ Unk.

42. Did the infant/child have a CSF cell count or CSF protein test? (137) (Footnote g) 1 ☐ Yes, one or both elevated 2 ☐ Yes, both not elevated 3 ☐ No test 9 ☐ Unk.

43. Was the infant/child treated? (138) 1 ☐ Yes, with Aqueous or Procaine Penicillin for ≥ 10 days 2 ☐ Yes, with Ampicillin followed by Aqueous or Procaine Penicillin for a total ≥ 10 days 3 ☐ Yes, with Benzathine penicillin x 1 4 ☐ Yes, with other treatment 5 ☐ No treatment 9 ☐ Unk.

PART IV. Congenital Syphilis Case Classification

44. Classification (139) 1 ☐ Not a case 2 ☐ Confirmed case (Laboratory confirmed identification of *T.pallidum*, e.g., darkfield or direct fluorescent antibody positive lesions) 3 ☐ Syphilitic stillbirth (Footnote d) 4 ☐ Presumptive case (A case identified by the above algorithm, which is not a confirmed case or syphilitic stillbirth).

State Of Virginia
Congenital Syphilis Case Investigation Worksheet On Mothers Instructions

Worksheets are to be submitted on all mothers with reactive prenatal or delivery serologies regardless of maternal treatment history.

- **Name:** - List name first. Include AKA in parentheses.
  Example: Williams, Terri (Houston, Tammy)

- **DOB:** - Mother's date of birth.

- **Race:** - Indicate the following: B = Black, W = White, O = Other, Hisp = Hispanic, Asia/PI = Asian/Pacific Islander, AI/AN = American Indian/Alaskan Native.

- **Address:** - Complete the address of the mother.

- **State:** - State of residency of mother.

- **Zip Code:** - Self-explanatory.

- **Telephone Number:** - Including area code of mother.

- **Previous STD History:** - List all known positive STDs.

  Prenatal Care: - (Indicate)"Yes" if mother has had prenatal care. OR "No" if mother has made no prenatal visits. If unknown, indicate by writing "Unk".

- **Date of First Prenatal Care Visit:** - If the answer to prenatal care is "Yes", indicate the date that a prenatal care record was opened. If the mother received prenatal care, the date of first prenatal care visit must be entered. Do not answer if answer to prenatal care is "No" or "Unknown".

- **Date of LMP:** - This indicates the mother's last menstrual period. If unknown, mark it as: 99/99/99.

  Location: - List the prenatal care provider's name and phone number.

- **Physician:** - List the physician who attended the mother.

- **Number of Visits:** - If answer to prenatal care is "Yes", indicate the number of prenatal visits the mother made. **Do not answer if prenatal care was "No or Unknown."**

- **Expected Due Date:** - Indicate the expected date of delivery.

- **Other Comments:**

- **Report Source:** - Indicate the type of clinic, provider or other entity providing the program the initial information that led to the classification of a case. When in doubt, ask "where did the case come from"?

- **Report Date:** - Indicate the date you received the case.

STS HISTORY (LIST MOST RECENT TEST):

- **Last Negative STD:** - Indicate the last known negative serology.

- **Type of Test: Results: Date: Facility:** - List all known maternal serological test for syphilis regardless of date of test and/or results. Please list in reverse chronological order, from the most current to the first test performed. List type of test, the result, date, test and facility that performed the test.

- **Date of Treatment:** - Enter the date of treatment for the disease diagnosed.

- **Treatment Given:** - Enter the dug, dosage, for each medication given.

- **Diagnosis:** - Enter the diagnosis of the patient at the time of treatment.

- **Symptom History:** - List any symptoms that relate to syphilis.

- **EPI LINK Y/N:** - Indicate "Yes" if case is epidemiologically linked to an existing syphilis case, and attach copy of the appropriate visual case analysis chart. If no link established indicate "No".

- **Date of Interview:** - Enter the date you interviewed the patient.

- **Worker Number:** - Enter the worker number for the Health Counselor who has been assigned this case for follow-up.

- **Region:** - Enter the region where the patient lives.

Reason for Investigation:

- **Prenatal STS:** - Enter the date of the first prenatal serology.

- **STS at Delivery:** - Enter the date of the serology at time of delivery.

- **STD after Delivery:** - Enter the date of serology after delivery.

- **Date Initiated:** - Enter the date when the mothers test results were reported to the health department.

- **Date Closed:** - Date the supervisor signs off on the tracking form.

State Of Virginia
Congenital Syphilis Case Investigation Worksheet On Infants Instructions

- **Name:** - Name of infant being investigated.
- **DOB:** - Date of birth of infant being investigated.
- **Mother's Name:** - Enter the name of infant's mother.
- **Primary Caretaker:** - List the name of the primary caretaker for the child and his/her relationship to the child, if not the mother.
- **Medical Care Provided by:** - Name of the doctor or medical provider of the infant.
- **Symptomatic *(describe)*:** - Indicate symptoms listed on medical record (i.e., condylyoma lata, snuffles, syphilitic skin rash, etc.)
- **Asymptomatic *(describe)*:** - State "Yes" if there isn't a history of symptoms, otherwise, leave blank.
- **Type of Test: Results: Date: Facility:** - List all known infant serological test for syphilis regardless of date of test and/or results. Please list in reverse chronological order, from the most current to the first test performed. List type of test, the result, date of test and facility that performed the test.
- **Long Bone X-Ray Findings:** - Did infant have a long bone x-ray? If "Yes", indicate the results.
- **CSF Findings:** - Did infant have a CSF serology? If "Yes", indicate the results.
- **Treatment:** - Enter the drug, dosage for each medication given.
- **Date:** - Enter the date of treatment.
- **Mother Adequately Treated 30 day Prior to Delivery:** - (Yes/No) If mother was treated adequately 30 days prior to delivery, answer "Yes". If treatment occurred less than 30 days, answer "No".
- **Congential Case Investigation Form (Yes/No):** - A CDC 126 should be completed if you answered "No" to number 13.
- **Work Number:** - Enter the worker number of the Health Counselor who has been assigned this case for follow-up.
- **Region:** - Enter the region where the patient lives.

- **Date Initiated:** - Enter the date of the infant's test results where reported to the health department.

- **Date of disposition:** - Date the supervisor signs off on the tracking form.

Sexually Transmitted Diseases

Health History and Physical Examination

ame _____ DOB _____ PIN _____ Date _____

Chief Complaint

Reason for Visit:

Referred by: _____

Positive Lab Test by: _____

Volunteer: ☐ Contact: ☐ Syphilis ☐ GC ☐

Medical History

Allergy: ☐ No ☐ Yes

to _____

☐ Current Medications

_____

_____

Menses: ☐ Regular ☐ Irregular

Explain _____

LMP _____

Now Pregnant ☐ No ☐ Yes

Past VD History

☐ No

☐ Yes List _____ Times _____ Last _____

_____ _____ _____

_____ _____ _____

Contraception Method None ☐

☐ BTL ☐ Vasectomy

☐ Pill ☐ Condom

☐ IUD ☐ Other _____

Symptoms ☐ None

No	Yes		Duration (Days)
☐	☐	Discharge	_____
	☐	Dysuria	_____
	☐	Lesion	_____
	☐	Rash	_____
	☐	Itching	_____
☐	☐	Abdominal Pain	_____
☐	☐	Other _____	_____

Exposure Information

Date Last Exposure _____

Partner Problem _____

_____

Exposure sites

☐ Vaginal ☐ Rectal ☐ Oral

Physical Examination ☐ Not Done

B/P _____

No	Yes				
☐	☐	Discharge	☐ Scant	☐ Mod.	☐ Heavy
			☐ Clear	☐ White	
			☐ Frothy	☐ Cheesy	☐ Purulent
			☐ Odor		
☐	☐	Lesion			
☐	☐	Rash			
☐	☐	Nodes			
☐	☐	Other _____			

Describe

Pelvic Examination ☐ Not Done

Describe

WNL	Abnormal	
☐	☐	Vulva
☐	☐	Vagina
☐	☐	Cervix
☐	☐	Bimanual
☐	☐	Other _____

ner _____

-10 (10/86)

Laboratory Examination

Done		Neg	Pos	Neg ex-cell Dipe ld
☐	Gramstain Urethra	☐	☐	☐
☐	Gramstain Cervix	☐	☐	☐
	Darkfield	☐	☐	
☐	PPB	☐	☐	
☐	Wet Prep _____	☐	☐	
☐	KOH	☐	☐	
☐	Chlamydia	☐	☐	
☐	Other _____	☐	☐	

Done		Neg	Pos
☐	Urethral Culture	☐	☐
☐	Cervical Culture	☐	☐
☐	Rectal Culture	☐	☐
☐	Pharyngeal Culture	☐	☐
☐	RPR Titer _____	☐	☐
☐	MHA-TP	☐	☐
☐	FTA-ABS	☐	☐
☐	Other _____	☐	☐

Diagnosis/Impression ☐ Test Only

Disease _____

Follow-Up Information

☐ Call For Results _____
☐ TOC Date _____
☐ Return To Clinic _____
☐ Referred To _____

Treatment Date _____ ☐ None

☐ Bicillin, 2.4 Million Units,IM
☐ Aq.Pro. Pen. G. 4.8 Million Units,IM; 1 g Probenecid
☐ Ampicillin, 3.5 g. P.O., 1 g Probenecid
☐ Doxycycline, P.O., 100 mg BID x 7 Days
☐ Tetracycline, P.O., 500 mg QID x 7 Days
☐ Tetracycline, P.O., 500 mg QID x 10 Days
☐ Tetracycline, P.O., 500 mg QID x 15 Days
☐ Spectinomycin, 2 g, IM
☐ Erythromycin 500 mg QID x 7 Days
Other (Specify) _____

Special Instructions _____
Ordered by _____
Administered by _____
M.D. Signature _____

Counseling/Instruction:

☐ Medication Instruction
☐ Medication Side Effects
☐ Disease Prevention/Safer Sex Practices
☐ Other

Epidemiologic Information

	No	Yes
Contact Interview	☐	☐

Interviewed by _____

Follow-up Visits

Date: _____
Reason For Visit: _____
Post Treatment Sex: ☐ No ☐ Yes
Symptoms:
☐ Resolved ☐ Improved ☐ Same ☐ Worse

Laboratory Examination:	Neg	Pos
☐ RPR	☐	☐
☐ Urethral Culture	☐	☐
☐ Cervical Culture	☐	☐
☐ Rectal Culture	☐	☐
☐ Pharyngeal Culture	☐	☐
☐ Wet Prep	☐	☐

☐ Other _____
Examiner _____
Additional Medication _____
Referred by _____
Instructed by _____
MD Signature _____

Physical Examination ☐ Not Done **Describe**

No	Yes				
☐	☐	Discharge:	☐ Scant	☐ Mod.	☐ Heavy
			☐ Clear	☐ White	
			☐ Frothy	☐ Cheesy	☐ Purulent
			☐ Odor		
☐	☐	Lesion			
☐	☐	Rash			
☐	☐	Nodes			
☐	☐	Other _____			

Pelvic Examination ☐ Not Done **Describe**

WNL	Abnormal	
☐	☐	Vulva
☐	☐	Vagina
☐	☐	Cervix
☐	☐	Bimanual
☐	☐	Other _____

Examiner _____

SEXUALLY TRANSMITTED DISEASES
HEALTH HISTORY AND PHYSICAL EXAMINATION
CHS-10

PURPOSE:

The CHS-10 is used to document the assessment and treatment of all health department patients receiving STD clinical services.

EXPLANATION:

Name:	Last, first, middle initial (include nicknames if indicated).
Birthdate:	Self-explanatory.
Patient Identification Number:	Locally assigned identifying number (See Health Care Records Manual).
Date Admitted:	Date admitted to health department for this particular episode.
Chief Complaint:	Enter, in the patient's own words, the reason he/she is seeking health care. Examples: "I think I caught the clap"; "I have a discharge."
Reason for Visit:	Determination of epidemiologic status.
Referred by:	Enter the name of any physician, health care facility, or agency who referred patient for care.
Positive lab by:	Name of clinic or facility performing test on referred patients.
Volunteer:	Check if patient presented to clinic on their own volition.
Contact:	Check if patient is a contact to an individual(s) with a diagnosed infection.

Syphilis/GC: Check if a contact to syphilis and/or gonorrhea. If a contact to another STD (Chlamydia, NGU, trich, etc.) write in appropriate diagnosis.

Medical History

Drug Allergy: Enter in red if there are known drug allergies; specify the name of the drug(s).

Current Medications: List all prescriptions and OTC drugs taken by patient. Include oral contraceptives.

Menses: Check the appropriate box. If irregular, describe under "Explain". Specify if irregularity involves frequency, amount of flow, associated discharge, pain, etc. Include length of time irregularity has been experienced.

LMP: Date of last menstrual period.

Now Pregnant: Check appropriate box. If pregnancy status has been recently confirmed by physical exam and/or test, enter date and location exam/test performed.

Past VD History:

Check appropriate box. If "yes", list the diagnoses, number of times patient treated for that particular diagnoses, and date of last occurrence.

Example

☐ No

☐ Yes List Gonorrhea Times 3 Last 12/85

Contraception Method: Check appropriate box(es). If "none", counsel patient regarding desire for children. If children not presently desired or planned,

inform patient of family planning services. Document the referral under "Follow-up Information" section.

Please Note: All male homosexuals should be questioned regarding regular use of condoms.

Symptoms: If patient denies any symptoms check "None". Otherwise check "No" or "Yes" according to patient response. Note the duration (date of onset to present) in days. The location should also be entered for discharge, lesion, rash, and itching. If "other" is checked, specify nature of symptom.

Exposure Information:

Date Last Exposure: Enter date of last sexual encounter.

Partner Problem: Enter significant signs or symptoms the patient's sexual partner(s) is experiencing. Example: penile discharge.

Exposure Sites: Check all sites of exposure.

Physical Examination:

If no physical examination is done, check "Not Done".

B/P - Enter Results. If abnormal, patient should be counseled and/or rechecked and referred per Hypertension Protocol. If referred, so note under "Follow-up Information."

Check "No" or "Yes" for sign detected/observed. Describe the finding as to the location, size, etc.

Pelvic Examination:

If patient is a male, leave this section blank. If no pelvic examination is done, check "Not Done". When a pelvic examination is done, check "WNL" (within normal limits) or "abnormal" for each item listed. If "abnormal" is checked, specify nature of abnormality.

Examiner: Signature and title of professional performing physical and pelvic examination.

Laboratory Examination:

Stat tests are listed on the left side of the form. When a stat test is done, check "DONE" beside appropriate test. When results of stat test are obtained, check the appropriate block, "Neg." or "Pos." For the two Gramstain tests there is a third result block "Neg. x-cell Diplo ID". If a Gramstain is negative, but gram negative extracellular diplococci are identified, then check this block. If the "Neg., x-cell Diplo ID" block is checked, the patient should be considered to be infected with gonorrhea and treated accordingly.

Other laboratory tests are shown on the right side of the form. Check the "DONE" block beside those tests which are performed. When result slips return from the laboratory, they are to be attached to form CHS-9 for inclusion in the Medical record. Results may be transcribed to the health history and physical examination form in the Laboratory Examination section next to the appropriate test. (Note: all results are "Pos." or "Neg." except the VDRL. If the VDRL is non-reactive, enter "NR". If the VDRL is reactive, enter "R" and the titer, i.e. R 8 dils.)

Diagnosis/Impressions:

If the patient presents "just for a check-up", no pathology is noted during physical examination and patient is not known to be epidemiologically linked to an infection, check "test only" and note date patient is to call for results or return to clinic. If referred elsewhere, indicate clinic or facility to which referred. If the patient is found to be infected with an STD or suspected of being infected, enter diagnosis/impression under "Disease".

Follow-up Information:

Check if patient is instructed to return or call and enter the date on which they are to do so. If the patient is referred, enter name of resource being referred to and reason for referral. Example: Norfolk General Hospital, hypertension follow-up.

Treatment:

Enter date treatment is given. If no treatment ordered, check "none". The most commonly used drugs and dosages are listed. If one of these is selected for use, check the block beside the selected drugs and dosage. Enter site of administration.

Other: If a course of treatment other than one listed above is selected, the drug and dosage selected should be written in the space provided.

Special Instructions: Self-explanatory.

Ordered By: If verbal order (V.O.) or telephone order (T.O.) obtained for medication, enter name of physician giving verbal/telephone order, date and time order received, and signature and title of nurse/nurse practitioner receiving order. Example: T.O., Dr. Jones, 1/26/86, 3:30 p.m., Sally Jones, R.N., P.H.N.

Counseling/Instructions:

Medication Instructions: Check this box if patient received instruction on proper method of self-administering medication.

Medication Side Effects: Check this box if the patient was instructed about the side effects of the medication and actions to take if side effects occur.

Disease Prevention/Safer Sex:

Check this box when the patient has been counseled on disease prevention through safer sexual practices. The counseling should include: a discussion of the patient's current sexual practices; the risks of disease transmissions; a discussion of limiting sex partners; refraining from unprotected anal/vaginal/oral sex; sharing sex toys; the use of condoms, and, if needed, an explanation of the proper way to put them on and remove them.

Epidemiologic Information:

Contact/Interview: Check if the contact interview was performed.

Interviewed By: Signature and title of interviewer. Epidemiology Representatives are to include their interviewer number.

Follow Up Visit:

This spaoe is provided to document the findings of a follow up visit which is related to the infection which was assessed/treated in the previous sections of this form.

Date: Enter date of follow visit.

Reason for Visit: TOC, RC-1, etc.

Post Treat Sex: Check appropriate block - (Post treatment sex is important in determining whether a patient is reinfected or a treatment failure).

Symptoms: Check appropriate block based upon the patient's evaluation of his symptoms.

Lab: Check appropriate lab test(s) performed. If "other", specify.

Examiner Signature: Self-explanatory.

Additional Medication: Give name, dosage, frequency and method of administering.

Ordered By: Enter name of M.D. giving verbal/telephone order; date and time order received; signature and title of nurse/nurse practitioner receiving order.

Administered By: Signature and title of professional administering medication.

M.D. Signature: See instructions for "M.D. Signature" under Treatment.

Physical Examination and Pelvic Examination:

See prior instructions.

Mechanics:

1. If the patient has received other health department services, the STD Field Test Form will be incorporated into the existing patient record.

2. If the patient does not have an existing record, a basic STD record will be initiated which includes:

   CHS-1 (Application for health care);

   CHS-5 (Problem List);

   CHS-10 (STD Health History and Physical Examination);

   CHS-6 (Progress Notes) as needed;

   CHS-9 Laboratory Reports

3. Placement of the CHS-10 shall follow the forms placement sequence in the Health Care Records Manual, pp. 12A & 13A.

Disposition and Retention:

Retained as specified in record retention schedule.

Replenishment of Stock:

Stocked in Central Services, order on ADM 1321.

★U.S. GPO: 2001-636-238

Last Name	First (& Nicknames)	Address (Street)	(Apt.#)	Home Phone

City	State	Zip	Age/D.O.B.	Race	Ethnicity	Sex	Marital Status
				W B A/PI AI/AN O/U	H Non-His.	M F	S M W D SP U

Height	Size/Build	Hair	Complexion	Pregnancy Status	Place of Employment/Hours/Phone
				Y ____ wks N U	

Exposure First	Exposure Freq.	Exposure Last	Original Patient ID Number	Other Identifying, Locating, or Medical Information

REFERRAL BASIS:	Disease 1	Disease 2	Initiating Agency
☐ Partner ____			
☐ Cluster ____			Invest. Agency
☐ Positive Lab Test			
☐ OOJ/ICCR ____			Clinic Code

Examination Date	Test	Result	Provider

Treatment Date	Drug	Dosage	Provider

FR Number	OOJ No.	OOJ Area	Due Date
3143012 D			

Disease 1			
Interviewer Number:			Disposition:
Date Initiated:	/ /	New Case #:	Dispo. Date: / /
Type Interview:			Diagnosis:
Type Referral:		Post-test Counseled? ☐ Yes ☐ No	Worker Number:

Disease 2			
Interviewer Number:			Disposition:
Date Initiated:	/ /	New Case #:	Dispo. Date: / /
Type Interview:			Diagnosis:
Type Referral:		Post-test Counseled? ☐ Yes ☐ No	Worker Number:

Field Record
CDC 73.2936S Rev 5/01

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention

Note: See the reverse side of page one of this record for the codes and the reverse side of pages two and three for an abbreviated set of instructions. See the full set of Field Record instructions for further definition.

Field Record CDC 73.2936S

The revised Field Record was patterned after the older Sexually Transmitted Disease Epidemiologic Report form. It had been called variously the ER, the ERF, the "green," and the .2936.

The Field Record contains four copies of a 5" by 8" form on different colored paper. Patient description, location, and case disposition information are noted on the field record. Once filled out, the copies are separated and kept in files that serve different functions. Filing systems may vary by locality. Your supervisor will inform you of the procedures used in your area.

One copy may have its information transferred into a computer data base system such as Epi Info. Another copy may be kept in the registration area of the clinic in an "expected-in" box. When the patient comes in and registers, this copy is put with the medical record so that the clinician will know which disease is suspected.

A third copy is usually kept in the DIS work area so that all DISs will have information at hand in case a patient calls on the phone and wants to know why he or she is being sought. The fourth, or green, copy is traditionally put into the "pouch" and taken into the field with the DIS. The pouch is a small binder with dividers that allows the DIS to organize the Field Records and prioritize field activities. DIS make notes of their investigation on the back of the "green".

Beginning on the following page are a sample Field Record and instructions for its completion.

Last Name (1) | First (& Nicknames) | Address (Street) (2) | (Apt.#) | Home Phone (3)

City (4) | State (5) | Zip (6) | Age/D.O.B. (7) | Race (8) W B A/PI AI/AN O U | Ethnicity (9) H Non Hisp | Sex (10) M F | Marital Status (11) S M W D SP

Height (12) | Size/Build (13) | Hair (14) | Complexion (15) | Pregnancy Status Y (16) wks N U | Place of Employment/Hours/Phone (17)

Exposure (18): First | Freq. | Last

Original Patient ID. Number (19)

Other Identifying, Locating, or Medical Information (20)

REFERRAL BASIS: (21) Disease 1 | Disease 2

Partner ___

Cluster ___

Positive Lab Test ___

OOJ/ICCR ___

Initiating Agency (22)

Invest. Agency (23)

Clinic Code (24)

Examination

Date (25)	Test	Result	Provider

Treatment

Date (26)	Drug	Dosage	Provider

FR Number (27)	OOJ No. (28)	OOJ Area (29)	Due Date (30)

Disease 1 (31)

Interviewer Number: (A)

Date Initiated: (B)

Type Interview: (C)

Type Referral: (D)

New Case #: (I)

Post-test Counseled? (J) Yes No

Disposition: (E)

Dispo. Date: (F)

Diagnosis: (G)

Worker Number: (H)

Disease 2

Interviewer Number: (A)

Date Initiated: (B)

Type Interview: (C)

Type Referral: (D)

New Case #: (I)

Post-test Counseled? (J) Yes No

Disposition: (E)

Dispo. Date: (F)

Diagnosis: (G)

Worker Number: (H)

Field Record

CDC 73.2936S (8/91)

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Centers for Disease Control

Note: See the reverse side of page one of this record for the codes and the reverse side of pages two and three for an abbreviated set of instructions. See the full set of Field Record instructions for further definition.

FIELD RECORD
Instructions and Code Descriptions for the Field Record (73.2936S)

The Field Record is used to assist the Epidemiology Representative (Epi. Rep.) in case management and it provides space to record observations and results. Certain information from the Field Record can be transferred to the Interview Record (73.54). These instructions describe how to complete the Field Record (73.2936S). Each numbered item in the instructions directly corresponds to the number on the sample record. The Field Record is to be completed at the time of the reactor or partner/cluster initiation. Use this form when attempting to locate sex and/or needle-sharing partners of original cases after interviews, or HIV seropositive patients who need post-test counseling, or STS reactive persons who need assessment of their syphilis status.

Note: An abbreviated version of the Field Record instructions can be found on the reverse side of the second and third pages of the Field Record. Additionally, the "Month/Day/Year" (MM/DD/YY) format should be utilized for all date fields on this record.

1 - **Name:** Enter the full name - last name first. Aliases/nicknames used by the individual should also be entered here.

2 - **Address:** Enter the complete address.

3 - **Home Phone:** Enter the phone number of the patient, partner, or cluster you are trying to locate.

4 - **City:** Enter his/her city of residence.

5 - **State:** Enter his/her state of residence using the two-letter post office abbreviation.

6 - **Zip:** Enter the zip code of the residence.

7 - **Age/D.O.B.:** Enter the age or the estimated age of the partner, cluster, or HIV-positive or STS-positive person. If known, give date of birth. (MM/DD/YY)

8 - **Race:** Enter an "X" in the appropriate box:

W(White) - A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

B(Black) - A person having origins in any of the original black peoples of Africa.

A/PI(Asian or Pacific Islander) - A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian sub-continent, or the Pacific Islands. (Examples: China, India, Japan, Korea, and Samoa.)

AI/AN(American Indian or Alaskan Native). A person having origins in any of the original peoples of North America who maintains cultural identification through tribal affiliation or community recognition.

9 - **Ethnicity:** Enter an "X" in the appropriate box to identify Hispanic origin.

10- **Sex:** Enter an "X" in the appropriate box to identify sex.

11- **Marital Status:** Enter an "X" in the appropriate box to identify marital status of the partner/cluster.

S	- Single	D	- Divorced
M	- Married/Common Law	SP	- Separated
W	- Widowed	U	- Unknown

12- **Height:** Enter an estimate of the height of the partner/cluster according to the original patient.

13- **Size/Build:** Enter an estimate of the weight and body build of the partner/cluster according to the original patient.

14- **Hair:** Enter the color and style of the partner/cluster's hair according to the original patient.

15- **Complexion (Skin):** Enter the color and appearance of the complexion of the partner/cluster as described by the original patient.

16- **Pregnancy Status:** Check the appropriate box for the current pregnancy status. Indicate the duration of pregnancy in weeks. If the duration of pregnancy is not known, enter the best estimate.

17- **Place of Employment:** Enter as much information as possible such as the name of the company, complete address, phone number, and the hours worked of the partner/cluster. If unemployed, then enter "unemployed". If unknown, enter "unk".

18- **Exposure:** Enter the dates of exposure (sex and/or needle-sharing) provided by the original patient for the partners.

First - Enter the date of first exposure. *(MM/DD/YY)

Freq. - Enter the frequency of exposure to the original patient; do not use terms such as "marital" or "steady".

For example: frequency should be described as:

1X - Single exposure.
15X - Fifteen times.
3/wk - Three times per week.
99 - Unknown
Last - Enter the date of last exposure. (MM/DD/YY)

***Any exposure in prior years should be recorded as month and year.**

19- **Original Patient ID Number** Enter the control number, medical record number, case number, or other locally assigned identifiers. If a computerized case management system is utilized, it is **essential** that the related control number from the interview record of the original patient be recorded here.

20- **Other Identifying, Locating, or Medical Information:** This area is for local use. It may be used for maps, landmarks, car driven, physical traits, hangouts, etc. Positive test and treatment information may be documented here or in the "Examination" and "Treatment" sections of this record. If additional space is needed for documentation, use the back copy of the Field Record.

21- **Referral Basis:** Enter an"X" in the appropriate box:

A. Partner: This individual was named by the original patient as having a sex, needle-sharing, or both types of relationship with the original patient.

In the space provided, enter the type of relationship:

Partner Codes:

P1 - Sex Partner
P2 - Needle-sharing Partner
P3 - Both Sex and Needle-Sharing Partner

Disease 1, Disease 2: Enter the Disease 1 or Disease 2 codes of the original patient.

100 - Chancroid
200 - Chlamydia
300 - Gonorrhea
350 - Resistant Gonorrhea
351 - Pregnant Females with Gonorrhea
352 - Repeaters with Gonorrhea
400 - Non-Gonococcal Urethritis
450 - Mucopurulent Cervicitis
490 - Pelvic Inflammatory Disease Syndrome
500 - Granuloma Inguinale
600 - Lymphogranuloma Venerum

700 - Syphilis Reactor
710 - Primary Syphilis
720 - Secondary Syphilis
730 - Early Latent Syphilis
740 - Latent Syphilis, Unknown Duration
745 - Late Latent Syphilis
750 - Late Syphilis @ Symptomatic Manifestations
760 - Neurosyphilis
790 - Congenital Syphilis
800 - Warts
850 - Herpes
900 - HIV
950 - AIDS (Syndrome)

Example: A sex partner of a patient with secondary syphilis would have the partner box checked, and "P1" (sex partner) entered on the line, and "720" (secondary syphilis) in the "Disease 1" box.

B: Cluster: This individual has been identified as a suspect or associate. Supsects are named by an infected person and associates are named by an uninfected person. In the space provided, enter the relationship.

Suspects:

S1 - Suspect who has or had symptoms suggestive of the identified disease.
S2 - Suspect who is described as a partner of another infected individual.
S3 - Suspect who could benefit from an exam and/or appropriate testing.

Associate:

A1 - Associate who has or had symptoms suggestive of the identified disease.
A2 - Associate who is described as a partner of another infected person.
A3 - Associate who could benefit from an exam or appropriate testing.

C. Positive Lab Test: This record is initiated for follow-up on a positive laboratory test result obtained through screening, private physicians, or other sources. If this is a syphilis reactor, enter Disease Code "700" in the applicable space. If this is HIV, enter code "900".

D. **OOJ/ICCR:** This record is initiated due to information obtained from another jurisdiction.

OOJ/ICCR Codes
1 - Partner
2 - Cluster
3 - Positive Lab Test

Example: For a person with a reactive syphilis serology from another jurisdiction, check this box, enter "3" on the line (lab test), and enter "700" in the "Disease 1" box (reactor).

22 - **Init.Agency:** Enter the appropriate FIPS county code of the initiating agency, use state FIPS codes for out-of-state.

23 - **Inv.Agency:** If different from above, enter the name or code number of the health department or other agency actually conducting the investigation.

24 - **Clinic Code:** If applicable, enter the specific clinic code identifying the initiating clinic.

25 - **Examination:** Enter the Date, Test, Result, and Provider for each test performed on this partner/cluster, HIV-positive or STS-positive reactor.

26 - **Treatment:** Enter the Date, Drug, Dosage, and Provider for each medication for this partner/cluster/HIV-positive or STS-positive reactor.

27 - **FR Number** (Field Record Number): This is a pre-printed number which may be entered on the interview record in the **"FR Num"** section.

28 - **OOJ (Out-of-Jurisdiction) NO:** Enter the new Field Record Number that will be used in the receiving area if this is sent to another jurisdiction for completion.

29 - **OOJ Area:** Enter the name of the area where the out-of jurisdiction Field Record is sent.

30 - **Due Date:** Enter the expected date for the completion of the investigation by the receiving area (generally two weeks).

31 - **Disease 1, Disease 2:** Summary Information

A. **Interviewer Number:** Enter the number of the Epi. Rep. who initiated the Field Record for follow-up. **If this Field Record is not initiated as a partner/cluster investigation, then leave blank.**

B. **Date Initiated:** Enter the date this partner, cluster, HIV-positive or STS-positive person is initiated for Epi. Rep. follow-up. (MM/DD/YY)

C. **Type Interview:** Enter the code for the type of interview that provided sufficient information in order to initiate this Field Record. **If this Field Record is not for a partner/cluster investigation, leave blank.**

O - Original Interview (with the original patient)
R - Re-interview (with the original patient)
C - Cluster Interview (original patient, partner, cluster)
P - Posttest Counseling Session (original patient)
U - Unable to interview*

***Partners/clusters were initiated although the original partner was not interviewed (includes those records initiated from a record search of previous cases).**

D. **Type Referral:** (For partners/clusters only)

Patient: Enter a "1" if the original patient was responsible for the referral of this individual for examination/treatment.

Provider: Enter a "2" if an Epi. Rep. investigation was responsible for the referral of this individual for examination/treatment.

E. **Disposition:** Includes STD and HIV dispositions.

STD DISPOSITION

A - Preventive Treatment - The partner/cluster was examined and treated but infection was not found by lab tests/clinical evidence.

B - Refused Preventive Treatment - The partner/cluster was examined and infection was not found. However, the partner/cluster refused preventive therapy.

C - Infected, Brought to Treatment - The partner/cluster sero-reactor was examined and treated (for the suspected infection) as a direct result of this field investigation. If the individual was treated prior to the initiation of this Field Record, the disposition will be "E".

D - Infected, Not Treated - The partner/cluster was examined/tested but not adequately treated (refused treatment or treatment status unknown). For this, there must be information from a health care provider which indicates the presence of the infection.

E - Previously Treated for this Infection - The partner/cluster/sero-reactor was adequately treated for the disease suspected prior to the initiation of a Field Record.

F - Not Infected - The tests/exam for the suspected disease are negative and preventive therapy was not required for this individual.

G - Insufficient Info to Begin Investigation - There is not sufficient information to warrant an investigation. This disposition should always be discussed with a supervisor. This is an administrative disposition and should not be used if any investigative effort is expended. In such instances, a disposition "H - Unable to Locate" is the correct one. When appropriate for FRs that were received from an out-of-jurisdiction location, this disposition should be accompanied by an explanation.

H - Unable to Locate - The partner/cluster or seropositive was not found after a **thorough** Epi. Rep. investigation. This disposition should always be reviewed with a supervisor. To ensure quality control, it is recommended that the following minimum number of resources be exhausted before this disposition is used: Department of Motor Vehicles, detention centers, major hospitals, probation authorities, major community health centers, community-based organizations, etc. If the infection status of a seropositive is known, use disposition "D".

J - Located, Refused Examination - The partner/cluster was found but refused examination. This disposition should always be reviewed and initialed by a supervisor before being given as final.

K - Out-of-Jurisdiction - The partner/cluster has moved from the jurisdiction and locating information is available to forward it for continued investigation.

Note: Appropriate action should be taken to forward the necessary information to the new jurisdiction.

L - Other - This disposition is to be used when none of the above dispositions apply. Document the reason why this disposition was selected.

HIV DISPOSITION

1 - **Previous Positive** - The partner/cluster had a previous positive HIV test.

2 - **Previous Negative, New Positive** - The partner/cluster has seroconverted.

3 - **Previous Negative, Still Negative** - The partner/cluster still has a negative test result.

4 - **Previous Negative, Not Re-Tested** - The partner/cluster has a negative test result, but is not re-tested at this time due to a recent test or other circumstances.

5 - **Not Previously Tested, New Positive** - The partner/cluster has no documented previous test and is a new HIV-positive.

6 - **Not Previously Tested, New Negative** - The partner/cluster has not been previously tested (or is unable to document previous test), and has tested negative for this investigation.

7 - **Not Previously Tested, Not Tested Now** - The partner/cluster has not been previously tested and is still not tested after investigation.

Note: See the STD Disposition section for the definition of dispositions G-L.

Note: If HIV testing was conducted, the assumption for the disposition rationale is that pre-test counseling was conducted. Only in disposition "J" can "refusal of pre-test counseling" be documented. For the two dispositions where persons are "not infected" and "not tested now," this may be due to recent testing, acceptance of counseling but refusal of testing, etc.

F. Dispo Date: Use the appropriate date as it relates to the following examination or treatment situation:

1. **Examined and treated** - Use the date of treatment.

2. **Examined, not treated** - Use the date examined (tested). Document the HIV disposition date this way.

3. **Not examined** - Use the date the investigation is closed.

G. Diagnosis (1, 2): Diagnosis refers to only new cases related to the original patient.

H. Worker #: Enter the number of the worker who performed this investigation (brought the field record to final disposition).

I. New Case #: If applicable, enter the IR control number for the partner/cluster/reactor. The case numbering system is a local area issue.

J. Post-test Counseled? Indicate whether or not partner/cluster was post-test counseled, if tested for HIV.

Interview Record

Note: See the reverse side of page one of this record for the codes and the reverse side of pages two and three for an abbreviated set of instructions. See the full set of Interview Record instructions for further definition.

Disease: 1. [ ] 2. [ ]

Control Number A 2568345

Patient Name (Last)	(First & Nicknames)	Case #	Inform ID.

Home Address (Street)	City	Res. Co.	State	Zip Code	Home Phone

Date of Birth	Age	Race	Ethnicity	Sex	Pregnant?	Pregnancy in Last 12 Mos.?
		W B A/PI AI/AN O/U	H Non-His.	M F	Y ___ Wks. N U	Y N U

Method of Case Detection:

- [ ] Provider Ref. To: ____
- [ ] Cluster To: ____
- [ ] Patient Ref. To: ____
- [ ] Prenatal
- [ ] Delivery
- [ ] Instit. Screening
- [ ] Community Screening
- [ ] Reactor
- [ ] Provider Report
- [ ] Volunteer

Information Source

Supv. No.	Clinic Code	Medical Record No.

	Date Assigned	Assigned to Wkr:	Date Treated	Case IX'D?	Interview Period	Period Partners Sex	N/S	Both
1.								
2.								

Since 1978: (Check All That Apply)

	Initial	Final
1. Sex w/ Male?	Y	Y
2. Sex w/ Female?	Y	Y
3. Used IV drugs?	Y	Y
4. Hemophilia?	Y	Y
Known Heterosexual Relations w/:		
5. IVDU?	Y	Y
6. Bisexual Male?	Y	Y
7. Person w/ Hemophilia?	Y	Y
8. HIV Positive Transfusion Recip.?	Y	Y
9. Person w/ AIDS or HIV Risk UNK.?	Y	Y
10. One Born in Pattern II?	Y	Y
11. Rec'd Blood Transfusion?	Y	Y
12. Worked in Health Care Setting?	Y	Y
13. Sex for Drugs/Money?	Y	Y

1. Pre-Test Counseled? Y N
2. Tested for HIV? Y N R
3. Post-Test Counseled? Y N

Previous HIV Test: No P N I U
Date: ____
Provider: ____

Current HIV Test: No P N I U
Date: ____
Provider: ____

Symptoms

Onset Date	Duration (Days)	Description

Lab Results

Date	Test	Result

Treatment

1. ____
2. ____

Other Infections

INT No.	Date of Interview	Type	P/CL	Ref	Exposure Dates First	Freq.	Last	FR Num	Name	Sex	Disease 1 Disp	Disp Date	Diag	Wkr. No.	Disease 2 Disp	Disp Date	Diag	Wkr. No.	Post Test CNSL	SO/SP	Invst Agen
1																					
2																					
1																					
2																					
1																					
2																					
1																					
2																					
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2																					

Local Use: A B C D E F G

Date Closed (1):

Date Closed (2):

Interview Record CDC 73.54

The revised Interview Record was modeled after the older Infectious Syphilis Epidemiologic Control Record. At various times and places, it had been called the 9.54, the syphilis interview record, and the 73.54. The old record was used only for syphilis interviews while the new form will adapt to most STD interviews.

The Interview Record has three pages of carbonless copies and a back page which is the Original Patient Information Sheet. The Interview Record is divided in half. The top half primarily gives details about the original patient (OP) whose name appears at the top; the bottom half lists sex partners, needle-sharing partners, suspects, and associates linked to the OP.

Linkage to other case-related patients is made using numbers rather than names. In the upper right hand of the Interview Record is a Control Number; below that number are the Case Number and Informant ID Number. These numbers, along with the Field Record Number, cross-reference the OP with partners and clusters, the OP with other related cases, and related cases within the lot system. The lot system is a way of filing and managing related cases.

Code numbers are needed to provide much of the information on the Interview Record. Codes and their meanings are given in the instructions for the Interview Record and are also on the back of the form for easy reference.

The last page of the Interview Record form is the Original Patient Information Sheet. Although the information sheet is optional, it is very useful because it documents vital interview information not found on the other two official forms.

Fulfilling Interview Record data requirements should not alter the interview process

Effective interviewing will result in initiable partners and clusters. Information not required for initiating partners and clusters should be collected at the end of the interview. For example, questions relating to risk assessment that are not answered during the normal course of the interview should be withheld until locating information has been taken for all partners and clusters. Please note that the Interview Record is not designed to be completed in the presence of the patient.

Beginning on the following page are the Interview Record, the Original Patient Information Sheet, instructions for their use, and an attachment with further suggestions on documentation.

Interview Record

Disease: 1. (1) 2. (2)

Note: See the reverse side of page one of this record for the codes and the reverse side of pages two and three for an abbreviated set of instructions. See the full set of Interview Record instructions for further definition.

Control Number

Patient Name (Last) (3) (First & Nicknames) | Case # (4) | Inform ID (5)

Home Address (Street) (6) City | Res. Co. (7) | State (8) | Zip Code (9) | Home Phone (10)

Date of Birth (11) | Age (12) | Race (13): W B A/PI AI/AN O/U | Ethnicity (14): H Non-Hisp. | Sex (15): M F | Pregnant? (16): Y Wks N U | Pregnancy in Last 12 Mos.? (17): Y N U

Method of Case Detection: (18)
- Provider Ref. To. ____
- Cluster To: ____
- Patient Ref. To: ____
- Prenatal
- Delivery
- Instit. Screening
- Community Screening
- Reactor
- Provider Report
- Volunteer

Information Source (19)

Supv. No. (20) | Clinic Code (21) | Medical Record No. (22)

	Date Assigned	Assigned to Wkr:	Date Treated	Case IX'D?	Interview Period	Period Partners Sex	N/S	Both
1.	(23)	(24)	(25)	(26)	(27)		(28)	
2.								

1. Pre-Test Counseled? Y N
2. Tested for HIV? Y N R (29)
3. Post-Test Counseled? Y N

Previous HIV Test: No P N I U
Date: (30)
Provider:

Current HIV Test: No P N I U
Date: (31)
Provider:

Since 1978: (Check All That Apply) (32) — Initial / Final
1. Sex w/ Male?
2. Sex w/ Female?
3. Used IV drugs?
4. Hemophilia?

Known Heterosexual Reasons w/
5. IVDU?
6. Bisexual Male?
7. Person w/ Hemophilia?
8. HIV Positive Transfusion Recip.?
9. Person w/ AIDS or HIV Risk UNK.?
10. Ore Born in Pattern II?
11. Rec'd Blood Transfusion?
12. Worked in Health Care Setting?
13. Sex for Drugs/Money?

Symptoms

Onset Date	Duration (Days)	Description
		(33)

Lab Results

Date	Test	Result
	(34)	

Treatment (35)

Other Infections (36)

INT No.	Date of Interview	Type	P CL	Ref	Exposure Dates First	Freq.	Last	FR Num	Name	Sex	Disease 1 Disp	Disp Date	Diag	Wkr No.	Disease 2 Disp	Disp Date	Diag	Wkr No.	Post Test CNSL	SC SP
1																				
2																				
1																				
2																				
1																				
2	(37)		(39)	(41)		(42)			(44)			(46)								(48)
1																				
2		(38)	(40)					(43)		(45)										(47)
1																				
2																				
1																				
2																				
1																				
2																				
1																				
2																				

Local Use (50) A B C D E F G

Date Closed (1): (51) Date Closed 2:

INTERVIEW RECORD for STD/HIV PREVENTION
Instructions and Code Descriptions for the Interview Record (73.54)

The Centers for Disease Control (CDC) STD/HIV Prevention Interview Record is designed for use by state and local STD/HIV Epidemiology Representatives (Epi. Rep.) who interview individuals who have STD, HIV or AIDS. The intent of this interview activity is to identify other potentially infected persons who may need treatment, counseling, or other early intervention services. Local program priorities and/or regulations will determine who is interviewed. Recording interview information and the results of field activity on this form will assist programs in collecting useful information for planning and evaluation purposes. Additionally, local policy or legislation may restrict the documentation of HIV information on a written record. If this is the case, local programs should not use HIV sections of this record.

These instructions describe how to complete the interview record. Each numbered item in the instructions corresponds to the number on the sample record.

Note: An abbreviated version of the Interview Record instructions is printed on the reverse side of the second and third pages of the Interview Record. Additionally, the "Month/Day/Year" (MM/DD/YY) format should be utilized for all date fields on this record.

1. **Disease 1,2:** Enter the specific code(s) of the diseases diagnosed and interviewed. The form enables each program, depending on program priorities, to interview for one or two (dual/concurrent) infections for each patient during a single interview encounter.
   - **100 - Chancroid**
   - **200 - Chlamydia**
   - **300 - Gonorrhea**
   - **350 - Resistant Gonorrhea**
   - **351 - Pregnant Females with Gonorrhea**
   - **352 - Repeaters with Gonorrhea**
   - **400 - Non-Gonococcal Urethritis**
   - **450 - Mucopurulent Cervicitis**
   - ***490 - Pelvic Inflammatory Disease (Syndrome)**
   - **500 - Granuloma Inguinale**
   - **600 - Lymphogranuloma Venereum**
   - **700 - Syphilis Reactor**
   - **710 - Primary Syphilis**
   - **720 - Secondary Syphilis**
   - **730 - Early Latent Syphilis**
   - **740 - Latent Syphilis, Unknown Duration**
   - **745 - Late Latent Syphilis**
   - **750 - Late Syphilis with Symptomatic Manifestations**
   - **760 - Neurosyphilis**
   - **790 - Congenital Syphilis**
   - **800 - Genital Warts**

850 - Herpes
900 - HIV
****950 - AIDS (Syndrome)**

*To document interviewing of a patient with PID, enter the causative agent in "Disease 1 or 2" and enter the code for PID in the "Other Infection" section of this form below. (Example: If the infection is Gonococcal Pelvic Inflammatory Disease enter the code "300" in the "Disease 1" box and enter "490" (PID) in the "Other Infection" section of the form on the next page.

**To document interviewing for a patient with AIDS, enter the causative agent (HIV) in "Disease 1 or 2" and enter the code for AIDS in the "Other Infection" section of the form below.

Note: Code descriptions are printed on the back of the interview record for easy reference.

2. **Control Number:** This pre-printed number is supplied for data processing/control purposes to link related cases. If a computerized case management system is in place, it is **essential** that this number appear in the "Original Patient ID Number" section of the related Field Records.

3. **Patient Name:** Enter the patient's full name, last name first. Any aliases or nicknames should also be recorded here. Additional space for other names used can be documented on the fourth page of the interview record.

4. **Case Number:** If this case has been assigned a local number, enter it here. This is an optional field for local use.

5. **Inform ID:** Enter the control number of the original patient to which this case is related.

6. **Home Address:** Enter the patient's complete address including apartment number and city.

7. **Res. Co.:** Enter the FIPS (Federal Information Processing Standards) code for the county in which the patient resides.

8. **State:** Enter the standard 2-letter abbreviation for the state in which the patient resides.

9. **Zip:** Enter the 5-digit zip code for the address at which the patient resides.

10. **Home Phone:** Enter the phone number where the patient can be reached (including area code).

11. **Date of Birth:** Enter the patient's date of birth (month, day, year). Enter 99/99/99 if unknown, January 3, 1970 should be entered as 01/03/70.

12. **Age:** Enter the patient's age as of the last birthday. Enter 01 if age is less than one year or 99 if unknown.

13. **Race:** Enter an "X" in the appropriate box:
W (White) - A person having origins from any of the original peoples of Europe, North Africa, or the Middle East.

B (Black) - A person having origins from any of the original black peoples of Africa.

A/PI (Asian or Pacific Islander) - A person having origins from any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. These include China, India, Japan, Korea, and Samoa.

AI/AN (American Indian or Alaskan Native) - A person having origins from any of the original peoples of North America who maintains cultural identification through tribal affiliation or community recognition.

O/U (Other or Unknown) - Other, not specified, or unknown.

NOTE: A racial category and ethnicity must always be checked for each patient.

14. **Ethnicity:** Enter an "X" in the appropriate box to identify Hispanic origin - a person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin regardless of the race. Identify the ethnic group with which the patient identifies.

15. **Sex:** Enter an "X" in the appropriate box for male or female.

16. **Pregnancy Status:** Check the appropriate box for the current pregnancy status. Indicate the duration of pregnancy in weeks. If the duration of pregnancy is not known, enter the best estimate.

17. **Pregnancy in Last 12 Months?:** Determine if this patient has been pregnant in the last 12 months. If currently pregnant, a "Yes" answer indicates that the woman had another pregnancy within the past 12 months, not including her current pregnancy. Probe any "Yes" response to this question to determine if there is a possible undetected case of congenital syphilis or a syphilitic stillbirth. Suggested questions to probe with are: "Did a delivery take place?", "When?", "Where?", "How old is the baby now?", etc.

18. **Method of Case Detection:** Enter an "X" in the box which best describes how the interviewed patient came to the attention of the STD/HIV program. Check only one box. If in doubt, ask the question "How did we find out about this case?"

Provider Referred Partner - This case was identified through Epi. Rep. activity following an interview with another known case. This case is a named partner of a known case. The provider (health department or other) was involved in the referral of this individual.

Cluster - This case was brought to the attention of the program as a result of an Epi. Rep. cluster interview. This case was originally designated as a **Suspect** or **Associate.**

Patient Referred Partner - This case was referred to the program by another known case following an interview. This may be a named or unnamed partner. No provider involvement was necessary for this referral.

To: Enter the disease code of the known case to which the provider referral, cluster referral, or patient referral is reportedly related. (Example: Cluster TO: 710 (Primary Syphilis). Provider Referral to 900 (HIV).

Prenatal - This case was found as a result of prenatal screening.

Delivery - This case was found as a result of screening at the time of delivery.

Institutional Screening - This case was found through screening conducted in various community institutions (other than prenatal clinics and delivery services - see above) - such as correctional facilities, drug abuse treatment centers, emergency clinics, etc., where health care services may be delivered.

Community Screening - This case was found through screening or special testing by the program or community based organizations in a variety of community settings where health care services are not traditionally provided. Community settings include hangouts, bars, houses, apartment complexes, parks, neighborhoods, etc. This category also includes cases found through program-sponsored mobile clinics stationed in neighborhoods.

Reactor - This case was found as a result of routine syphilis reactor surveillance and follow-up by program staff.

Provider Report - This case was identified by a written or telephone report initiated by a private health care provider.

Volunteer - This case was self-referred to a STD clinic. An individual who is initially examined by a private physician and attends the STD clinic for diagnosis and treatment is also classified as a volunteer.

19 - **Information Source:** Enter the 2-digit code for the type of clinic, provider, or other entity providing the program the initial information that ultimately led to the classification of a case. When in doubt, ask the question "Where did the case come from?"

Information Source/Provider Codes

Clinics:	Other:
01 - HIV Counseling and Test	08 - Private Physician/HMO
02 - STD	09 - Hospital (Inpatient)
03 - Drug Treatment	10 - Emergency Room
04 - Family Planning	11- Correctional Facility
05 - Prenatal/Obstetrics	12 - Laboratory
06 - Tuberculosis	13 - Blood Bank
07 - Other Clinic	88 - Other
99 - Unknown	

20 - **Supv. No.:** Enter supervisor's assigned number.

21 - **Clinic Code:** If applicable, enter the code of the clinic at which this case was diagnosed. This is an optional field for local use.

22 - **Medical Rec. No.:** If known, enter patient's medical record number. For example, if this is a clinic patient, enter the clinic record number; if a hospital record, enter that number. This would be for reference purposes and local policy would dictate the necessity for this documentation.

23 - **Date Assigned:** Enter the date the FR was assigned for follow-up (MM/DD/YY).

24 - **Assigned to WKR.:** Enter the worker number for the Epi. Rep. who has been assigned this case for follow-up. (MM/DD/YY)

25 - **Date Treated:** Enter the date of treatment for the disease diagnosed. This field does not apply to HIV diagnosis - leave blank. For unknown treatment, use 99/99/99. Document the treatment in the "Treatment" section provided below. (MM/DD/YY)

26 - Case IX'D - (Case Interviewed?): Enter the appropriate letter to indicate if or where the patient was interviewed.

C(Clinic) - The patient was interviewed in the STD clinic.

F(Field) - The patient was interviewed while the Epi. Rep. was performing field activity.

U(Unable to Locate) - The patient was not located for an interview.

R(Refused) - The patient was located but refused the interview.

O(Other) - Specify in interview comments section (e.g., physician refused permission to interview).

27 - Interview Period: - Enter the interview period (in months) for each infection.

28 - Period Partners: - Enter the total number of sex and/or needlesharing partners claimed by the patient during the interview period.*

"Sex partners" are only those persons with whom the original patient has had sex and not shared needles.

"Needlesharing partners" are only those persons with whom the original patient has shared needles, but did not have sex.

"Both" are those persons with whom the original patient has had sex and shared needles.

***This includes initiated partners, marginal partners, anonymous partners, and partners not named. For example, the patient may claim 10 sex partners during the three-month interview period (Primary Syphilis), but only three can be initiated. 10 should be entered for "Sex", 0 for "N/S", and 0 for "Both".**

The question that should be asked is - "How many partners have you had during the last _____ months?" The number of months depends on the interview period.

29 - HIV Counseling and Testing Information: If HIV testing is available in this clinic, complete the following three items about patients for whom an Interview Record is otherwise initiated. Enter "X" in the appropriate box:

1 - Pre-Test Counseled? - The patient was pre-test counseled for HIV during this encounter (Yes, No).

Note: Y = The patient received pre-test counseling with the most recent clinical examination or was pre-test counseled during an interview.

2 - Tested for HIV? - If HIV testing was offered, did the patient receive a test (Yes, No, Refused)?

3 - Post-Test Counseled? - The patient was HIV post-test counseled in the clinic or field regardless of whether the results were positive or negative (Yes, No).

Note: Local policy will determine the use of this this section.

30 - **Previous HIV Test:** (Prior to the current encounter.)

A. Enter the appropriate response if this information can be obtained. Only **verified,** documented results should be entered in this section.

NO - No Previous Test Documented
P - Positive Test
N - Negative Test
I - Indeterminate Test
U - Unknown

B. Document the date of the test (MM/DD/YY)- and the provider code. Write the name of the provider in the space provided. Use the "Information Source" codes for documentation of the provider type.

31 - **Current HIV Test:**

A. Enter the current HIV test results for this patient.

NO - Not Done
P - Positive Test
N - Negative Test
I - Indeterminate Test
U - Unknown

B. Document the date of the test (MM/DD/YY) and the provider who performed the test. The name of the provider should be entered in the space provided.

32 - **Risk Assessment:** Risk assessment should occur for all persons who are interviewed. The initial assessment should be completed during the initial/original interview while the final assessment should be completed at case closure. All 13 factors should be assessed each time. (The final assessment incorporates new information gained from investigative activities.) It is possible to check several boxes in this section.

Check the "Yes" box if any of the following have occurred since January 1978.

1 - Sex w/male? - The patient's sexual relations were with a male.

2 - Sex w/female? - The patient's sexual relations were with a female.

3 - Used IV drugs? - The patient has used IV drugs, since 1978.

4 - Hemophilia? - The patient is a hemophiliac.

Heterosexual Relations w/Known:

5 - IVDU (IV Drug User?) - The patient has been a sex partner of an IV drug user.

6 - Bisexual male? - The patient has been a sex partner of a bisexual male.

7- Person w/hemophilia? - The patient has been a sex partner of a person with hemophilia.

8 - HIV positive transfusion recip.? - The patient has been a sex partner of a person who was infected with HIV through a blood transfusion.

9 - Person w/AIDS or HIV risk UNK.? - The patient has been a sex partner of an HIV-infected person whose risk is not specified.

10 - One born in Pattern II? - The patient has been a sex partner of a person born in a Pattern II country.

The current Pattern II (heterosexual transmission dominant) countries are as follows:

Afars and Issas
Angola
Benin
Botswana
Burundi
Cameroon
Central African Republic
Chad
Congo
Costa Rica
Equatorial Guinea
Ethiopia
Gabon
Gambia
Ghana
Guinea
Guinea-Bissau
Haiti
Ivory Coast
Kenya
Liberia
Malawi
Mali
Maurotamoa
Mozambique
Niger
Nigeria
Rwanda
Senegel
Sierra Leone
Sudan
Tanzania
Togo
Uganda
Upper Volta
Zambia
Zimbabwe Rhodesia

11 - Received blood transfusion? - The patient has been the recipient of blood/blood products during the time period 1978-1985.

12 - Worked in health care setting? - The patient has worked in a health care setting which could have potentially exposed the patient to contaminated body fluids, e.g., person working in an emergency room caring for trauma patients; person cleaning patients' rooms, especially those soiled with body fluids; person at risk for needle sticks, such as nurses, physicians, and phlebotomists. This does not include clerical and other such support staff working in health care settings.

13 - Sex for drugs/money? - The patient has given or accepted drugs or money in exchange for sex.

33 - **Symptoms**

Onset - Enter the date when patient first became aware of symptoms (MM/DD/YY).

Duration (Days) - Enter the number of days that symptoms were present.

Description - Briefly describe symptoms and site(s). Use a new line to document symptoms of separate occurrences of similar symptoms. For example, if two symptoms were identified, write "penile lesion" on first line and "macular/papular rash" on second line. If recurring secondary symptoms were identifed, use another line to document the new onset date, duration and description.

34 - **Lab Results** - Summarize all lab results relevant to this case, listing the most recent tests first.

Note: HIV status should be documented in the "Previous HIV Test" and/or "Current HIV Result" section of the form.

Date - Enter the date when the specimen was collected. (MM/DD/YY)

Test - Enter the type of test performed.

Result - Enter the laboratory findings.

35 - **Treatment:** Enter the adequate treatment regimen of the interviewed disease(s). If the disease is HIV, leave the line blank. Example - If Disease 1 is HIV and Disease 2 is secondary syphilis (the patient is treated with 2.4 MU benzathine penicillin), then enter 2.4 MU bicillin (or 2.4 bic) on line 2. Other treatment should be documented on the fourth page of the Interview Record. For the recommendations of adequate treatment, please see the current Treatment Guidelines.

36 - **Other Infections:** Enter the other infections and/or syndromes diagnosed in this patient. This includes those infections that do not usually require a patient interview in your program. This is the section where PID and AIDS should be listed if they are present in this patient and those conditions which stimulated a patient interview. The causative agents for PID and AIDS should be identified in the "Disease" section at the top of the form. Additionally, adequate follow-up on partners exposed to these infections should be ensured. A morbidity report should be attached for all "Other Infections", if reportable.

PARTNER/CLUSTER INITIATION

This section of the form is used to record all interview activity and the results of investigations. Guidelines for completing the partner/cluster initiation section are:

1. If a patient is interviewed, at least one line must be entered to document the interview activity.

2. If no interview is conducted, then a line is not completed; however, the "Case Interviewed" section must be completed.

3. All re-interview or cluster activity must be listed on separate lines.

4. Separate lines must be used to record results of initiable partners and clusters. If more lines are required, utilize another interview record. Disease 1, 2, Patient Name, and Case Number should be entered on the second form. Draw a line through the control number and put the control number of the original interview record in the space above.

   Enter only the names of sex or needle-sharing partners, suspects, and associates for **whom sufficient information has been obtained to initiate a Field Record.** For interviews of dually infected patients, a split- line is used to distinguish between Disease 1 and Disease 2 for Interview Number, Date of Interview, Type of Interview, Partner/Cluster, and Type of Referra

37 - **Int. No.(Interviewer Number):** Enter the interviewer's assigned number each time any type of interview activity related to the case occurs or to document the initiation of partners or clusters.

38 - **Date of Interview:** Enter the date the original interview, re-interview, cluster interview or post-test counseling was performed (MM/DD/YY).

39 - **Type:** Enter the type of interview:

O - Original interview (with the original patient)
R - Re-interview (with the original patient)
C - Cluster Interview (with the original patient, partner, cluster)
P - Post-Test Counseling (with the original patient)
*U - Unable to Interview.

*May include situations where the original patient was not interviewed, but sex partners, needlesharing partners, or clusters were initiated from a record search or cluster activity.

Note: General field screening should not be included in the summary information of a case. Other mechanisms must be used to collect this type of screening information.

40 - **P/CL (Partner/Cluster):** Enter the appropriate identifier for the specific type of partner/cluster that corresponds to Disease 1 or Disease 2:

N - No Sex/Needlesharing Partners/Cluster Initiated.

Note: If no partners or clusters are initiated during an interview, then enter the interviewer number, date of interview, type of interview, and "N" in the box marked "P/CL" (partner/cluster).

PARTNER - Persons having sex (activities of any type), sharing needles, or both activities with original patient.

P1 - Sex Partner.
P2 - Needlesharing Partner.
P3 - Both Sex and Needlesharing Partner.

SUSPECT - Persons named by an infected person (e.g., original patient).

S1 - Person who has or had symptoms suggestive of the condition listed in Disease 1 or Disease 2.

S2 - Person who is described as a sex partner of a known infected person.

S3 - Any other person who would benefit from an exam.

ASSOCIATE - Persons who are named by an uninfected partne: or cluster.

A1 - Person who has or had symptoms suggestive of th condition listed in Disease 1 or Disease 2.

A2 - Person who is described as a sex partner of a know: infected person.

A3 - Any other person who would benefit from an exam.

41 - **REF (Referral):** This only refers to initiated partners an clusters and describes how they are brought into the progra for examination. This documentation will take place at th time of disposition (closure) of the Field Record. **Do no complete for record closure.**

1 - Patient: No health department involvement in th referral of this partner/cluster.

2 - Provider: Epi. Rep. or other health department staf: were involved in the referral.

Note: The patient referral code should also be used if contract referral was kept and the program did no initiate field activity before the partner/cluster wa brought to the program.

42 - **Exposure Dates:** Enter the exposure information in thi section.

FIRST - Enter the date of first exposure. (MM/DD/YY)

FREQUENCY - Enter the frequency (number) of exposure t original patient between the first and last or mos recent exposure. This should be described a specifically as possible.

Single exposure - 1x

Multiple exposures - For example, three times wee (3/wk) or two times per month (2/mo).

Unknown - "99"

LAST - Enter the date of last exposure. (MM/DD/YY)

43 - **FR Num (Field Record Number of the 9.2936s):** Enter the Field Record control number for the partner/cluster initiated. (Located in the lower, left side of the 73.2936s).

44 - **Name:** - Enter the name of the partner/cluster with last name on the top line and first name on the bottom line.

45 - **Sex:** - Enter M = Male, F = Female, or P = Pregnant Female to indicate the sex of the partner/cluster initiated.

46 - **Disease 1, 2.** This information is derived from the Field Record. Disease 1 refers to information about the partner/cluster as it relates to Disease 1 of the original patient.

Disp (Disposition): Enter the disposition code from the Field Record. Refer to the Field Record instructions for further descriptions of the dispositions.

STD Disposition Codes for Partners/Clusters

A - Preventive Treatment
B - Refused Preventive Treatment
C - Infected, Brought to Treatment
D - Infected, Not Treated
E - Previously Treated for this Infection
F - Not Infected
G - Insufficient Information to Begin Investigation
H - Unable to Locate
J - Located, Refused Examination
K - Out of Jurisdiction
L - Other

HIV Disposition Codes for Partners/Clusters

1 - Previous Positive
2 - Previous Negative, New Positive
3 - Previous Negative, Still Negative
4 - Previous Negative, Not Re-Tested
5 - Not Previously Tested, New Positive
6 - Not Previously Tested, New Negative
7 - Not Previously Tested, Not Tested Now
G - Insufficient Information to Begin Investigation
H - Unable to Locate
J - Located, Refused Counseling and Testing
K - Out of Jurisdiction
L - Other

Note: If HIV testing was conducted, the assumption for the disposition rationale is that pre-test counseling was conducted. Only in disposition "J" can "refusal of pre-test counseling" be documented. For the two dispositions where persons are "not re-tested" and "not tested now", this may be due to recent testing, acceptance of counseling but refusal of testing, etc.

Disp Date (Disposition Date): Use the appropriate date as it relates to the following examination or treatment situation: (MM/DD/YY)

1. Examined and treated - Use the date of treatment.

2. Examined, not treated - Use the date examined. Document the HIV disposition date this way.

3. Not examined - Use the date the investigation is closed.

Diag (Diagnosis): Diagnosis refers to only cases related to the original patient. If an additional disease is diagnosed that is not related to the original patient, there are two options: 1) the new diagnosis becomes a new interview record and/or 2) the new diagnosis will only be documented in the local morbidity database.

Wrk No. (Worker Number): Enter the worker number of the Epi. Rep. who brought this Field Record to disposition.

47 - **Post-Test Cnsl?:** If the partner/cluster was tested for HIV, enter Y = Yes or N = No for whether or not the partner/cluster was post-counseled.

48 - **So/Sp (Source/Spread):** For syphilis original patients only, enter a "1" if the partner/cluster was the source of infection for this case or "2" if he/she was a spread. Case management analysis would guide in this determination.

49 - **Invst Agen (Investigating Agency):** Enter the FIPS code for the county to which this investigation was sent. This only applies to investigations sent out of your jurisdiction.

50 - **Date Closed:** Enter the date of case closure in space provided for each disease. The determination of closure should be made by the Epi. Rep. and the supervisor after all reasonable efforts have been expended on the case. (MM/DD/YY)

LOCAL USE FIELDS

Enter the number that corresponds with the following situation for each of the local use fields, A - E:

A - TB Skin Testing Data

1 - No PPD testing performed.
2 - PPD tested, results not interpreted.
3 - PPD tested, results negative, interpreted within 96 hours.

4 - PPD tested, results negative, interpreted in the field within 96 hours.
5 - PPD tested, results positive, interpreted within 96 hours.
6 - PPD tested, results positive, interpreted in the field within 96 hours.
7 - Previous PPD positive, x-ray conducted, no treatment necessary.
8 - Previous PPD positive, x-ray conducted, treatment indicated.
9 - Previous PPD positive, previously treated.

B - Patient Drug Use History, Part One: Drug of Choice
Note: This section does not include those drugs prescribed by a physician for medicinal purposes.

1 - Alcohol
2 - Crack
3 - Cocaine
4 - Heroin
5 - Marijuana
6 - Amphetamines
7 - Barbituates
8 - Two or More of the Above Listed Drugs
(note: indicate specific substances on the original patient intelligence sheet)

C - Patient Drug Use History, Part Two: Route of Ingestion

1 - Needle (I.V. or I.M.)
2 - Oral (tablet or smoke)
3 - Inhaled Through the Nose
4 - Other (note: specify on the original patient intelligence sheet)

D - Patient Drug Use History, Part Three: Partner's Drug Use and Route of Ingestion

1 - Crack/Inhaled
2 - Crack/Other
3 - Cocaine/Inhaled
4 - Cocaine/Needle
5 - Heroin/Needle
6 - Heroin/Other
7 - Other/Other

E - Census Tract Data

Enter the census tract code that corresponds with the patient's address specified above. This is an optional field for local use.

ORIGINAL PATIENT INFORMATION SHEET

Depending on an individual program area's priorities and focus, the utilization of this form will vary. The following is one method to obtain and document vital information that could be used during the investigation.

Document the name of the original patient, the case number, and the control number in the space provided. This will be helpful in maintaining organized records.

1 - **Address:** Enter all the addresses for the patient during the interview period. This can assist the Epi.Rep. in evaluating lifestyle, other partners/clusters in or near prior residences, etc.

2 - **Living With:** Enter the names of the individuals who stayed at this address. This information can be useful for identifying other partners/clusters or additional ways to contact patient.

3 - **Reason for Moving:** Enter the reason for moving. This information can assist in assessing lifestyle.

4 - **Living With:** Enter the persons(s) with whom the patient is currently living. This information can prepare the Epi. Rep. for who might be encountered on a follow-up visit or for additional lifestyle comments.

5 - **Relationship:** Enter the type of relationship the patient shares with those living at same residence (mother, friend, etc.). This further describes lifestyle. If married, where does spouse live?

6 - **Time at Address:** Enter the amount of time the patient has been at present address.

7 - **Marital Status:** Enter the marital status of the patient.

8 - **Employment/Means of Support:** Describe how the patient supports him/herself. Enter the name of the company, address, phone number, hours worked, and length of employment for patient. This information may be used to contact original patient if Epi. Rep. is unable to reach patient at home. If the patient is unemployed, from where does spending money come?

9 - **Emergency Locating:** Enter information on how to locate the patient should there be an emergency. For example, who could locate the patient within 24 hours?

10 - **Other Names Used:** Enter any nicknames or aliases of the patient. The patient may have other reports under different names or be named by a contact under another name.

11 - **Serologic History:** Enter any recent syphilis blood tests (positive or negative) for the patient. This information is used to determine stage, interview period, source/spread relationships, etc.

12 - **Previous RX for STD:** Enter any previous treatment (adequate, inadequate, self-treated, etc.) for STDs. Follow-up with other health care providers may lead to other relevant information about the case.

13 - **Interview Period Travel:** Enter the place, reason, dates, companions, and with whom the patient stayed during the interview period. This information can assist the Epi. Rep. to identify exposure gaps, elicit out-of-jurisdiction partners/clusters, etc.

14 - **Marginal Partners:** Enter all the obtained information on partners/clusters not initiated. If additional information is gained during the case follow-up, then initiate a field record and document the necessary information on the field and interview record.

INSTRUCTIONS FOR COMPLETING THE

CDC ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

(FOR HEALTH DEPARTMENT REFERENCE USE ONLY)

July 30, 1993

STATEMENT OF PUBLIC BURDEN:

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to PHS Reports Clearance Officer; ATTN: PRA; Hubert H. Humphrey Building; Room 721-B; 300 Independence Avenue, SW; Washington, D.C. 20201, and to the Office of Management and Budget; Paperwork Reduction Project (0920-0009); Washington, D.C. 20503.

INTRODUCTION AND PURPOSE:

The "CDC HIV/AIDS CONFIDENTIAL CASE REPORT" is a double-sided one-page form designed to collect, in a confidential manner, information that will assist in the understanding of HIV infection and AIDS. The HIV and AIDS reporting forms and software were combined at the recommendation of state and local reporting areas. The form and software incorporate suggestions and comments submitted by reporting areas. In addition to information collected on prior versions of HIV and AIDS reporting forms, the new merged HIV/AIDS case report form includes a more extensive laboratory data section and a new section for treatment services and referrals. The form is divided into ten sections that meet the information needs of local health departments and national data collection systems:

I. Local Use Only: Patient Identifying Information

II. Health Department Use Only
III. Demographic Information
IV. Facility of Diagnosis
V. Patient History
VI. Laboratory Data
VII. Local Use Only: Physician Identifying Information
VIII. Clinical Status
IX. Treatment Services/Referrals
X. Comments

The completed form is for state or local health agency use only and is **not** to be sent to CDC. Data obtained from these case report forms should be entered into standardized computer software provided by the Division of HIV/AIDS, National Center for Infectious Diseases, CDC and then transferred to CDC electronically by encrypted computer diskette to the CDC. To protect the confidentiality of the information, states are encouraged to use the phonetic alphanumeric code (SOUNDEX) for communications between health agencies in conjunction with the patient's date of birth and the state or city/county id number.

A case report form should be completed for each person found to be HIV-infected (in areas where HIV reporting is required by law) and for each person who meets the 1993 CDC surveillance case definition for severe HIV disease (AIDS). When a person who has been previously reported as HIV-infected has progressed to AIDS or has died, the form and software should be updated accordingly. The form can also be used to update CD4 counts and percents, the patient's clinical classification, and occurrences of additional opportunistic diseases. Shaded portions of the form are to be completed by the state or local health department personnel.

The HIV/AIDS Reporting System (HARS) software is menu driven and closely resembles the actual case report form. Data edit checks are built in to reduce local data-entry errors. The software also allows multiple updates of key patient information such as CD4 counts, opportunistic diseases, and demographic data.

As standard criteria, CDC requests that the following patient information be recorded, reported and updated:

1. The earliest date the person is documented to be HIV antibody positive by -- (a) laboratory report (i.e., a repeatedly reactive EIA screening test, supplemented by a positive Western Blot/IFA or other positive antibody test), or (b) positive HIV culture or positive HIV antigen or (c) the earliest date of physician diagnosis of HIV infection (In accordance with local laws).
2. For persons who meet the 1993 AIDS surveillance case definition, the date of the first AIDS-defining clinical condition or the first CD4 count below 200 cells/μL or CD4 percentage below 14.
3. Date of death.

Consistent with past practice, certain priority cases should continue to be discussed directly with CDC, independently of the HIV/AIDS reporting system. These include HIV infection in a health care worker or in a health care setting; HIV-2 infection; and cases attributed to tissue or organ transplantation, transfusions after March 1985, or unusual modes of transmission. This direct communication will ensure the most timely provision of technical support.

The data variables are italicized and underlined. Specific directions are written below each variable for further clarification. Instructions are arranged by individual sections on the case report form. Variables designated as "required" are needed for a record to be included in CDC's HIV/AIDS surveillance database.

SECTION I: STATE/LOCAL USE ONLY: Patient Identier Information

Patient information is for state/local health department use only and is not transferred to CDC.

PATIENT'S NAME

Enter the patient's last name, first name, and middle initial.

PHONE NO.

Enter the patient's current home area code and telephone number.

ADDRESS

Enter the patient's current address, including street number, street name, city, county, state, and zip code.

SECTION II: HEALTH DEPARTMENT USE ONLY

DATE FORM COMPLETED

Enter the date the form was completed for submission to the health department.

REPORT SOURCE

Enter the code for reporting source that initially reported the case to the health department. Valid reporting sources include private physicians/HMOs, death certificates, HIV report follow-ups, alternate databases (e.g., AZT Registry, Adult/Adolescent Spectrum of Disease Study, Medicaid records, Pediatric Spectrum of Disease Study, National Death Index Study, TB Surveillance Registry, Supplement to HIV/AIDS Surveillance), HRSA-funded clinics, coroner/medical examiners, and clinics (e.g., HIV counseling and testing, STD, drug treatment, family planning,

prenatal/obstetrics, pediatric, tuberculosis). If "other database," "other clinic,""other," or "out of state" is checked, please enter the information in Section X (Comments) of the HARS case report form. The software provides a field of 18 characters for entry of these "other" source fields not listed in the software.

SOUNDEX (Required)

The software generates this variable by using the patient's last name entered in Section I.

REPORT STATUS

Place a "√" in the appropriate box.

New report — Mark this box if the patient is being reported for the first time.

Update — Mark this box if the report is an update of a previous report. Reports of AIDS in patients who were previously reported as HIV infected are treated as updates.

REPORTING HEALTH DEPARTMENT

Write in the state, city, and county of the reporting health department.

STATE NO. (Required)

Enter the assigned state patient number. A unique number should be assigned for each patient, regardless of diagnosis status at first report. Each patient should have one unique state number throughout the course of HIV disease. **Assigned numbers should not be reused even if the case is later deleted.**

DATE OF BIRTH (Required)

Enter the patient's month, day, and year of birth.

CURRENT STATUS **(Required)**

Place a "√" in the appropriate box to indicate patient's current vital status.

DATE OF DEATH

If the patient has died, enter the date of death.

STATE/TERRITORY OF DEATH

If the patient has died, enter the name of the state or territory where the death occurred.

SEX **(Required)**

Place a "√" in the box corresponding to the patient's sex at birth.

RACE/ETHNICITY **(Required)**

Place a "√" in the box corresponding to the patient's race or ethnicity.

In direct response to requests from reporting areas during field testing, we have included a variable called "Extended Race" in the HARS software. This variable is not required for reports transmitted to CDC.

COUNTRY OF BIRTH

Place a "√" in the box corresponding to the patient's country of birth. If this information is not available from the HIV or CD4 laboratory report form, it can be left blank and updated on follow-up. U.S. dependencies and possessions include as the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Federated States of Micronesia, the Republic of Palau, and the Marshall Islands.

RESIDENCE AT DIAGNOSIS

If HIV infection is being reported, enter the patient's city, county, state/country, and zip code of residence at the time of the first confirmatory test for HIV infection. If a laboratory report is not available, enter the patient's residence at the date of physician diagnosis of HIV infection. If the residence is unknown, write "unknown" in the space provided and leave blank when entering in the software.

If an AIDS case is being reported, enter the patient's residence at the date of the first AIDS-defining clinical condition or the date of the first CD4 lymphocyte test below 200 cells/μL or the first CD4 lymphocyte percentage below 14. If the residence is unknown, write "unknown" in the space provided and leave blank when entering in the software.

Computer software will record and maintain the patient's residence both when HIV infection was diagnosed and when AIDS was diagnosed.

SECTION IV: FACILITY OF DIAGNOSIS

FACILITY NAME

If HIV infection is being reported, enter the name of the facility where the patient first had blood drawn and was diagnosed with HIV infection. If test results are not in the medical record, enter the name of the facility where the patient's HIV infection was diagnosed and documented by the health-care provider. If a facility name is not documented but a physician's name is listed, enter the name of the physician here.

If an AIDS case is being reported, enter the name of the facility where the patient was first diagnosed with an AIDS-defining clinical condition, or a CD4 count below 200 cells/μL or CD4 percentage below 14 documented, whichever came first.

Computer software will record and maintain both the facility where HIV infection was diagnosed and the facility where AIDS was diagnosed.

CITY-STATE/COUNTRY

If HIV infection is being reported, enter the city, state, and country where the facility is located.

If an AIDS case is being reported, enter the city, state, and country where the facility is located.

FACILITY SETTING

Place a "√" in the box corresponding to the facility setting.

If the report is from a private doctor or clinic, '*private*' should be checked as facility setting.

If the report is from a public clinic or hospital, '*public*' should be checked as facility setting.

If the report is from a Veteran's Administration facility, military hospital or clinic, '*federal*' should be checked as facility setting.

FACILITY TYPE

Place a "√" in the box corresponding to the facility type. *Physician, HMO* should be checked if the facility where this diagnosis was made is a private outpatient care site not associated with a hospital. If the facility is not a *Physician, HMO* or *Hospital, Inpatient*, write in the type of facility in the space provided.

Examples of "other" facility types include HIV counseling and testing sites, STD clinics, drug treatment facilities, family planning clinics, prenatal/obstetrics clinics, tuberculosis clinics, correctional facilities, medical examiner's office, emergency rooms, and outpatient hospitals. These examples are guidelines for data abstraction and are not exhaustive of all possible facility types. A pull-down menu of facility types is provided in the computer software.

SECTION V: PATIENT HISTORY

This section collects information on the presumed modes by which the patient acquired his/her infection. Only risks occurring after 1977 and before the diagnosis of HIV or AIDS should be collected. **RESPOND TO ALL CATEGORIES.**

- Sex with male
- Sex with female
- Injected nonprescription drugs
- Received clotting factor for hemophilia or coagulation disorder

  If yes, please specify the disorder.
- HETEROSEXUAL relations with any of the following:

  Intravenous or injection drug user

  Bisexual male

  Person with hemophilia or coagulation disorder

  Transfusion recipient with documented HIV infection

  Transplant recipient with documented HIV infection

  Person with AIDS or documented HIV infection, risk not specified

  (This category should only be checked if the heterosexual partner is known to be HIV positive, but their risk for HIV is unknown.)

- Received transfusion of blood or blood components (other than clotting factor)

  If yes, specify the month and year of the first and last transfusions before the patient was infected with HIV or diagnosed with AIDS.

- Received transplant of tissue or organs or artificial insemination

(If this is the only risk history, the case will be initially classified as 'other/undetermined' pending outcome of the no identified risk [NIR] investigation.)

- Worked in a health-care or clinical laboratory setting

  If yes, specify the patient's occupation. (If this is the only risk history present, the case will be initially classified as 'other/undetermined' pending outcome of the no identified risk [NIR] investigation.)

SECTION VI: LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS:

(Indicate first test)

If HIV infection is being reported, indicate the results and test date for HIV antibody tests performed at diagnosis of HIV infection.

If an AIDS case is being reported, indicate the results and test date for HIV antibody tests performed at diagnosis of AIDS.

Results for persons previously reported with a positive HIV laboratory test result who have now seroconverted, should be recorded in the space provided for '*Date of last documented negative HIV test (specify type)*'.

- HIV-1 EIA

Indicate the result of the first HIV-1 EIA. Positive EIA designates repeatedly reactive tests on a single sample. Enter the month and year of test. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year.

- HIV-1/HIV-2 combination EIA

Indicate the result of the first HIV-1/HIV-2 combination EIA test. Positive HIV-1/HIV-2 combination test designates repeatedly reactive tests on a single sample. Enter the month and year of test. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year.

- HIV-1 Western blot/IFA

Indicate the result of the first HIV-1 Western blot/IFA. Enter the month and year of the test. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year.

- Other HIV-1 test

If another HIV-1 test was conducted, specify the type of test performed. Indicate the result. Enter the month and year of the test. If a year is present without a designated month,"99" should be entered as the month, followed by the documented year.

- HIV-2 EIA

Enter the result of the first test. Enter the month and year of the test. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year.

•HIV-2 Western blot

Enter the result of the first test. Enter the month and year of the test. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year.

2. *POSITIVE HIV DETECTION TEST*

Enter the month and year of their earliest positive detection tests (e.g., culture, antigen, PCR, DNA or RNA probe) performed.

•DATE OF LAST DOCUMENTED NEGATIVE HIV TEST (SPECIFY TYPE):

Enter the type of HIV antibody test performed. Enter the date of the last documented negative HIV test. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year.

•IF HIV LABORATORY TESTS WERE NOT DOCUMENTED, IS HIV DIAGNOSIS DOCUMENTED BY A PHYSICIAN?

Check the appropriate box.

A physician diagnosis is made by clinical or laboratory evidence of HIV infection. Documentation by a physician of HIV infection by patient history or patient self report is not considered a 'physician diagnosis'.

IF YES, PROVIDE DATE OF DOCUMENTATION BY PHYSICIAN.

If laboratory evidence of an HIV test is unavailable in the patient's medical or other record and written documentation of positive HIV test is noted by the physician, enter the date that the physician diagnosed HIV. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year.

3. *IMMUNOLOGIC LAB TESTS:*

AT OR CLOSEST TO DIAGNOSIS

•CD4 COUNT

For HIV reports, record the CD4 count at or closest to the time the patient is determined to be HIV infected. If this information is not available when the initial case report is completed it may be entered later. For AIDS reports, record the CD4 count at or closest to the time that an AIDS-defining clinical condition was diagnosed. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year.

•CD4 PERCENT

For HIV reports, record the CD4 percent at or closest to the time the patient is determined to be HIV infected. If this information is not available when the initial case report is completed, it may be entered later. For AIDS reports, record the CD4 percent at or closest to the time that an AIDS-defining clinical condition was first diagnosed. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year.

FIRST < 200 cells/μL or < 14%

•CD4 COUNT

Record the first CD4 count less than 200 cells/μL. Record month and year of this test.

•CD4 PERCENT

Record the first CD4 percent less than 14. Record month and year of this test.

SECTION VII: STATE/LOCAL USE ONLY: Physician Identier Information

PHYSICIAN'S NAME

For HIV infection reports, enter the name of the physician ordering the test. For AIDS case reports, enter the name of the physician providing medical management to the patient. If the test was provided as part of a visit to a health department, STD clinic, HIV counseling and testing site, or other facility where no single individual is responsible for medical management of the patient, leave this space blank and complete the "Facility of Diagnosis" section appropriately.

PHONE NO.

Enter the telephone number of the physician named above. If no physician is named, enter the phone number of the facility where the report originated should be entered.

MEDICAL RECORD NO.

Enter the medical record number if a patient has been hospitalized as an inpatient or treated as an outpatient in a hospital, community health center, or health department clinic. If the patient has both inpatient and outpatient records at the same facility, the number of the primary record should be recorded in this section. Any additional medical record numbers can be noted in the "comments" section.

HOSPITAL/FACILITY

Enter the name of the hospital or clinic where the report originated. If this report is generated from a laboratory report of HIV infection, the laboratory slip should contain the name of the facility where the specimen was collected. The software will include fields for recording the name and location of laboratory facilities for states wishing to use this information for surveillance tracking purposes.

PERSON COMPLETING FORM

Enter the name of the person who completed the form or the name of a person who can be contacted to clarify entries and supply additional medical or locating information on the patient.

PHONE NO.

Enter the telephone number of the person completing the form.

SECTION VIII: CLINICAL STATUS

CLINICAL RECORD REVIEWED

Check the appropriate box.

ASYMPTOMATIC (including acute retroviral syndrome and persistent generalized lymphadenopathy [PGL])

If there is documentation that the patient is asymptomatic (Group A1 and A2) as outlined in the 1993 CDC Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS among Adolescents and Adults, enter the date of evaluation. This category includes HIV-positive persons with no HIV-related symptoms, with acute retroviral illnesses, or with PGL. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year. The software will not allow entry code of "99" for unknown year; instead it will be interpreted as an entry for the year 1999.

SYMPTOMATIC (not AIDS)

If there is documentation of symptomatic (Group B1 and B2) conditions as outlined in the 1993 CDC Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS among Adolescents and Adults or if the conditions are documented to be "HIV-related," record the date of evaluation. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year. The software will not allow entry code of "99" for unknown year; instead it will be interpreted as an entry for the year 1999.

AIDS INDICATOR DISEASES

Check all AIDS indicator diseases and enter dates of diagnosis that apply. If a year is present without a designated month, "99" should be entered as the month followed by the documented year. The software will not allow entry code of "99" for unknown year; instead it will be interpreted as an entry for the year 1999.

Definitive diagnoses are based on specific laboratory methods such as histology or culture. These methods are detailed in the 1987 and 1993 MMWR case definition supplement and recommendations (1987:36:1-15S and 1992:41:1-17RR).

Presumptive diagnoses are made by the clinician. The methods of diagnosis listed in the case definition supplement are guidelines only, and any method that the clinician considers diagnostic should be accepted.

RVCT CASE NO.

If this patient is a verified tuberculosis case, enter the nine-digit alphanumeric code from the case report.

IF HIV TESTS WERE NOT POSITIVE OR WERE NOT DONE DOES THIS PATIENT HAVE AN IMMUNODEFICIENCY THAT WOULD DISQUALIFY HIM/HER FROM THE AIDS CASE DEFINITION?

Check the appropriate box. Causes of immunodeficiency that disqualify clinical conditions as indicators of AIDS in the absence of laboratory evidence for HIV infection are:

1. High-dose or long-term systemic corticosteroid therapy or other immunosuppressive/cytotoxic therapy within 3 months before the onset of the AIDS-defining clinical condition.
2. Any of the following diseases diagnosed before or within 3 months after the AIDS-defining clinical condition was diagnosed: Hodgkin's disease, non-Hodgkin's lymphoma (other than primary brain lymphoma), lymphocytic leukemia, multiple myeloma, any other cancer of lymphoreticular or histiocytic tissue, or angioimmunoblastic lymphadenopathy.
3. A genetic (congenital) immunodeficiency syndrome or an acquired immunodeficiency syndrome atypical of HIV infection, such as one involving hypogammaglobulinemia.

SECTION IX: TREATMENT SERVICES/REFERRALS

This section should be completed by the person initially notifying the health department of the HIV/AIDS patient. **Many questions in this section may only apply to states that conduct HIV surveillance.**

- *HAS THIS PATIENT BEEN INFORMED OF HIS/HER HIV INFECTION?*

  Check the appropriate box. If notification is not documented, "Unknown" should be indicated unless the person completing the form knows with certainty that the patient has been informed.

- *This patient's partners will be notified about their HIV exposure and counseled by:*

  Check the appropriate box.

- *This patient is receiving or has been referred for:*

  HIV related medical services

  Check the appropriate box.

  Substance abuse treatment services

  Check the appropriate box.

- *This patient received or is receiving:*

  Anti-retroviral therapy (e.g., zidovudine [AZT], didanosine [ddI], dideoxycytidine [ddC])

  Check the appropriate box.

  PCP prophylaxis (e.g.,Bactrim, Septra [TMP/SMX], pentamidine).

  Check the appropriate box.

- *This patient has been enrolled at*

  Clinical Trial:

  Check the appropriate box.

  Clinic:

  Check the appropriate box.

- *This patient's medical treatment is primarily reimbursed through:*

  Check the appropriate box.

FOR WOMEN

- *Has this patient been receiving or been referred for gynecological or obstetrical services?*

  Check the appropriate response.

- *Is this patient currently pregnant?*

  Check the appropriate response.

- *Has the patient delivered live-born infants?*

  Check the appropriate response. If yes and delivered after 1977, provide birth information for the most recent birth in the section below. Information on additional births can be recorded the Section X and in the local fields section of the software.

Child's Date of Birth

Enter the child's month, day, and year of birth.

Hospital of Birth

Enter the name, city, and state of the hospital where the child was born. If the child was born at home, enter "Home birth." If unknown, enter "Unknown." Do not leave blank; an entry is required.

Child's Soundex

To be completed by state/local health department personnel. If the child has been entered in your current HARS database and a *stateno* exists, retrieve the

soundex code from the database and enter here. If the child has not been entered in the database, enter the name and date of birth information in the HARS software. The child's surname will be converted to a Soundex code when entered into the HARS software. Identifiers collected in this section are not transmitted to CDC.

Child's State Patient No.

To be completed by state/local health department personnel. Assigned by state/local health department personnel if the child is known to be HIV infected. **State patient numbers must not be reused.**

SECTION X: COMMENTS

This section can be used for information not requested on the form. DO NOT place identifying information in the corresponding section of the HARS software.

INSTRUCTIONS FOR COMPLETING THE CDC PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT FORM

(FOR HEALTH DEPARTMENT REFERENCE USE ONLY)

August 1, 1993

INTRODUCTION AND PURPOSE:

The "CDC PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT" is a double-sided two-page fold out form designed to collect, in a confidential manner, information that will assist in the understanding of HIV infection and AIDS. The HIV and AIDS reporting forms and software were combined at the recommendation of state and local surveillance personnel. The new form and software incorporate comments suggested by local and state reporting areas. In addition to information collected on prior versions of HIV and AIDS reporting forms, the new merged HIV/AIDS case report form includes an expanded laboratory data section and new sections for treatment, services and referrals, and birth history for perinatal cases. The form is divided into eleven sections which record information needs of local health departments and national data collection systems:

I. Patient Identifier Information: State/Local Use Only
II. Health Department Use Only: Reporting Health Department Information
III. Demographic Information
IV. Facility of Diagnosis
V. Patient/Maternal History
VI. Physician Identifier Information: State/Local Use Only
VII. Laboratory Data
VIII. Clinical Status
IX. Birth History (for Perinatal cases only)
X. Treatment/Services Referrals
XI. Comments

The completed form is for state or local health agency use only and should **not** be sent to CDC. Data obtained from these case report forms should be entered into standardized computer software provided by the Division of HIV/AIDS, National Center for Infectious Diseases, CDC and then transferred to CDC electronically by encrypted computer diskette. To protect the confidentiality of the information, states are encouraged, whenever possible, to use the phonetic alphanumeric code (SOUNDEX) for communications between health agencies in conjunction with the patient's date of birth, sex, and the state or city/county patient number.

A case report form should be completed for each child with confirmed HIV infection (in areas where HIV reporting is required by law) and for each child who meets the 1987 pediatric CDC surveillance case definition for severe HIV disease (AIDS). In areas where permitted by law and where resources allow, a case report form can be completed for each child who is born to an HIV infected mother, is less than 15 months of age and does not meet the criteria for confirmed HIV infection (i.e., indeterminate HIV infection status). When a child who has been previously reported as HIV-infected has progressed to AIDS or has died, the form and software should be updated accordingly. Similarly, when a child who has been previously reported as perinatal HIV exposure with indeterminate HIV infection status has been diagnosed with confirmed HIV infection or has seroreverted, the form and software should be updated accordingly. Follow-up to determine whether there is a change in status of the patient (i.e., confirmed HIV infection, diagnosis of AIDS, seroreversion, or death) should occur at routine intervals, whenever possible. These intervals (i.e., every six months) should be determined by individual reporting areas. For example, reports of perinatal HIV exposure with indeterminate infection status should be updated after 15 months of age, at a minimum, to determine HIV infection status. The form can also be used to update CD4 counts and percents, the patient's clinical classification, and occurrences of additional opportunistic diseases. Shaded portions of the form are to be completed by the state or local health department personnel.

The HIV/AIDS Reporting System (HARS) software is menu driven and closely resembles the actual case report form. However, the software allows for the collection of up to nine different laboratory test results with dates, for HIV-1 or HIV-1/HIV-2 combination EIA, HIV-1 Western blot/IFA, other HIV-1 antibody tests, positive HIV detection tests, and CD4 counts and percents. Data edit checks are built in to reduce local data-entry errors. The software allows multiple updates of key patient information such as CD4 counts, opportunistic diseases, and demographic data.

Below are criteria for pediatric HIV/AIDS case reporting. These include perinatal HIV exposure with indeterminate infection status, confirmed HIV infection, AIDS and seroreverter. Please refer to the 1987 Pediatric AIDS case definition and the 1987 Classification System for Human Immunodeficiency Virus (HIV) Infection in Children Under 13 years of Age (see appendix A, B). As standard criteria, CDC requests that patient information be recorded, reported and updated to reflect the earliest date that the child meets these criteria, in addition to their vital status. (In accordance with local laws):

PLEASE NOTE: **The pediatric classification system, which includes the definition of HIV infection, is currently under revision. As soon as this is published, the instructions and software will be updated and distributed.**

Perinatal HIV **Exposure (Indeterminate HIV Infection Status)**

A child who is born to an HIV infected mother, is less than 15 months of age, does not meet the criteria for confirmed HIV infection, and has a repeatedly reactive EIA screening test, and/or a positive Western blot, IFA, or other confirmatory test or, born to an HIV-infected mother but the child's antibody status is unknown.

Confirmed HIV Infection

The criteria for confirmed HIV infection:

For a child < 15 months of age who is known to be HIV seropositive or born to an HIV-infected mother:

a) Detection of HIV virus by positive HIV virus culture or positive HIV antigen (p24) or positive HIV polymerase chain reaction (PCR) (excluding cord blood), **OR**

b) Diagnosis of AIDS based on the 1987 AIDS case definition, **OR,**

c) Documentation of physician diagnosis of HIV infection (Patients or parents/guardians self reports of HIV status are not acceptable).

For a child ≥ 15 months of age or for a child whose biologic mother was known to be HIV uninfected after the child's birth:

a) HIV antibody positive by repeatedly reactive EIA screening test supplemented by a confirmatory test (i.e., Western blot, IFA) **OR,**

b) Any criteria for children < 15 months of age, **OR**

c) Documentation of physician diagnosis of HIV infection (Patients or parents/guardians self reports of HIV status are not acceptable).

AIDS

The date of the first AIDS-defining condition (1987 pediatric AIDS case definition) (see appendix).

Seroreverter

A child born to an HIV-infected mother is considered to have seroreverted and is assumed to be uninfected when there is

documentation of a negative HIV antibody test after six months of age **AND** no other laboratory evidence of confirmed HIV infection **AND** no HIV-related symptoms. (Clinical conditions that are considered "HIV-related" are listed under Class P-2 in the 1987 Classification System for Human Immunodeficiency Virus (HIV) Infection in Children Under 13 Years of Age (see appendix B).

Death

Consistent with past practice, certain priority cases should continue to be discussed directly with CDC surveillance staff, independently of the HIV/AIDS reporting system. These include HIV infection in a health care setting; HIV-2 infection; HIV infection attributed to tissue or organ transplantation; suspected transmission due to sexual contact; mother-to-infant transmission due to breastfeeding; transfusions after March 1985; or unusual transmission circumstances. This direct communication will ensure the most timely provision of technical support.

DATA VARIABLES

Each data variable is italicized and underlined. Specific directions are written below each variable for further clarification. Instructions are arranged by individual sections on the case report form. Variables designated as "required" are needed for a record to be included in CDC's HIV/AIDS surveillance database.

SECTION I: STATE/LOCAL USE ONLY: Patient Identifier Information

Patient identifier information is for state/local health department use only and is not transmitted to CDC.

PATIENT'S NAME

Enter the patient's last name, first name, and middle initial.

PHONE NO.

Enter the patient's current home area code and telephone number.

ADDRESS

Enter the patient's current address, including street number, street name, city, county, state, and zip code.

SECTION II: HEALTH DEPARTMENT USE ONLY

Shaded areas are to be completed by state/local health department personnel.

DATE FORM COMPLETED

Enter the date the form was completed for submission to the health department.

REPORT SOURCE

Enter the code for reporting source (see appendix C for codes). Valid reporting sources include private physicians/HMOs, death certificates, HIV report follow-ups, alternate databases (e.g., AZT registry, Medicaid records, Pediatric Spectrum of Disease Study, National Death Index Study, TB surveillance registry, Supplement to HIV/AIDS Surveillance), HRSA-funded clinics, coroner/medical examiners, clinics (e.g., HIV counseling and testing, STD, family planning, prenatal/obstetrics, pediatric, tuberculosis, pediatric HIV specialty clinic), hospitals (inpatient or outpatient), and emergency rooms. These examples are not exhaustive of all possible sources of report. A pull-down menu of report source is provided in the computer software and is attached in the appendix. If "other database," "other clinic," "other," or "out of state" is checked, please enter the information in Section X (Comments) of the HARS

case report form. The software provides a field of 18 characters for entry of these "other" source fields not listed in the software.

SOUNDEX (Required to enter a case into HARS software)

The software generates this variable by using the patient's last name entered in Section I.

REPORT STATUS

Place a "√" in the appropriate box. This information is for your use only and is not entered into the HARS software.

New report — Mark this box if the patient is being reported for the first time or if it is unknown whether patient was previously reported.

Update — Mark this box if the report is an update of a previous report. Reports of AIDS in patients who were previously reported as HIV infected are treated as updates.

REPORTING HEALTH DEPARTMENT

Write in the state, city, and county of the reporting health department.

STATE PATIENT NO. (Required)

Enter the assigned state patient number. A unique number should be assigned for each patient, regardless of diagnostic status at first report. Each patient should have one unique state number throughout the course of HIV disease. **Assigned numbers should not be reused even if the case is later deleted.**

CITY/COUNTY PATIENT NO. (Required Where State No. Is Not Used)

Enter the unique city/county number for this patient if applicable. **Assigned numbers should not be reused even if the case is later deleted.**

For a child 15 months of age or greater or for a child whose biologic mother is known to be HIV uninfected at or after the child's birth:

a) Detection of HIV virus by positive HIV virus culture or positive HIV antigen (p24) or positive HIV polymerase chain reaction (PCR) (excluding cord blood), **OR**

b) HIV antibody positive by repeatedly reactive EIA screening test supplemented by a confirmatory test (i.e., Western blot, IFA) **OR,**

c) Documentation of physician diagnosis of HIV infection. (Patients or parents/guardians self reports of HIV status are not acceptable).

AIDS: Mark this box if the patient meets the 1987 CDC pediatric AIDS case definition.

Seroreverter: Mark this box if the patient was born to an HIV-infected mother is considered to have seroreverted and is assumed to be uninfected (i.e., documented HIV antibody negative after 6 months of age **AND** no other laboratory evidence of confirmed HIV infection **AND** no HIV-related symptoms). (Clinical conditions that are considered "HIV-related" are listed under Class P-2 in the 1987 Classification System for Human Immunodeficiency Virus (HIV) Infection in Children Under 13 Years of Age (see appendix B).

DATE OF BIRTH (Required)

Enter the patient's month, day, and year of birth.

AGE AT DIAGNOSIS

For reports of confirmed HIV infection (not AIDS), enter the patients's age at diagnosis of confirmed HIV infection. If a positive laboratory test result is not documented but a physician diagnosis of confirmed HIV infection is noted in the patient's medical record, enter the patient's age at physician diagnosis. (Please note: there is no field for age at diagnosis of perinatal HIV exposure with indeterminate infection status. However, age at first evaluation for HIV infection can be calculated by using the date of birth and the date of initial evaluation for HIV infection).

For AIDS case reports, enter the patient's age when the first AIDS-defining clinical condition was diagnosed.

Computer software will record and maintain the patient's age both at diagnosis of confirmed HIV infection and at diagnosis of AIDS.

CURRENT STATUS **(Required)**

Place a "√" in the appropriate box to indicate patient's current vital status.

DATE OF DEATH

If the patient has died, enter the date of death.

STATE/TERRITORY OF DEATH

If the patient has died, enter the name of the state or territory where the death occurred.

DATE OF INITIAL EVALUATION FOR HIV INFECTION

Enter the date when HIV infection was first considered, either clinically or through laboratory evaluation. HIV infection in a child can only be considered after the child has been born. It does not necessarily mean that an antibody test was ordered at that time, although documentation of an HIV test is often the earliest evidence that

the diagnosis was considered. For a child whose mother is known to be HIV positive at the time of birth and for whom assessment of HIV is done at birth, use the date of birth.

SEX **(Required)**

Place a "√" in the box corresponding to the patient's sex.

RACE/ETHNICITY **(Required)**

Place a "√" in the box corresponding to the patient's race or ethnicity.

In direct response to requests from reporting areas during field testing, we have included a variable called "Extended Race" in the HARS software. This variable is not required for reports and is not transmitted to CDC.

COUNTRY OF BIRTH

Place a "√" in the box corresponding to the patient's country of birth. If this information is not available, it can be left blank and updated on follow-up. U.S. dependencies, possessions and independent nations are Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Republic of Palau, the Republic of the Marshall Islands, the Commonwealth of the Northern Manana Islands, and the Federated States of Micronesia.

RESIDENCE AT DIAGNOSIS

If a case of confirmed HIV infection or perinatal HIV exposure with indeterminate HIV infection status is being reported, enter the patient's city, county, state/country, and zip code of residence at the time of the first confirmatory test for HIV infection or when HIV infection was first considered, either clinically or through laboratory evaluation. Documentation of an HIV test is often the earliest evidence that HIV diagnosis was considered, however, an HIV antibody test may not have been ordered at that time. If a laboratory report is not available, enter the patient's residence at

the date of physician diagnosis of HIV infection or when HIV infection was first considered by a physician.

If an AIDS case is being reported, enter the patient's residence at the date of the first AIDS-defining clinical condition.

Computer software will record and maintain the patient's residence both when HIV infection or perinatal HIV exposure was diagnosed and when AIDS was diagnosed.

SECTION IV: FACILITY OF DIAGNOSIS

FACILITY NAME

If you are reporting a case of perinatal HIV exposure with indeterminate HIV infection status, enter the name of the facility where the patient was first evaluated for HIV infection, either clinically or through laboratory evaluation. HIV infection in a child can only be considered after the child has been born. Therefore, the hospital where the mother obtained prenatal care should not be used to answer this question unless it was also the facility where the child was born and HIV infection was considered as a diagnosis at delivery or at subsequent physician/clinic visits. If a facility name is not documented but a physician's name is listed, enter "private physician" or a numeric code for each physician and enter the name of the physician under Physician Identifier Information (Section VI).

If you are reporting a case of confirmed HIV infection, enter the name of the facility where the patient was confirmed to be HIV infected. If test results are not in the medical record, enter the name of the facility where the patient's HIV infection was diagnosed and documented by the health-care provider. If a facility name is not documented but a physician's name is listed, enter "private physician" or a numeric

code for each physician and enter the name of the physician under Physician Identifier Information (Section VI).

If an AIDS case is being reported, enter the name of the facility where the patient was first diagnosed with an AIDS-defining clinical condition.

Computer software will record and maintain the facility where perinatal HIV exposure was first determined, the facility where HIV infection was confirmed, and the facility where AIDS was diagnosed.

CITY-STATE/COUNTRY

If you are reporting a case of perinatal HIV exposure with indeterminate HIV infection status, enter the city, state, and country where the facility is located.

If you are reporting a case of confirmed HIV infection, enter the city, state, and country where the facility is located.

If you are reporting a case of AIDS, enter the city, state, and country where the facility is located.

FACILITY SETTING

Place a "√" in the box corresponding to the facility setting.

FACILITY TYPE

Place a "√" in the box corresponding to the facility type. (see appendix for codes) *Physician, HMO* should be checked if the facility where this diagnosis was made is a private outpatient care site not associated with a hospital. If the facility is not *"Physician, HMO"* or *"Hospital, Inpatient"*, write in the type of facility in the space provided. Examples of "other" facility types include pediatric HIV specialty clinics,

outpatient hospital settings, emergency rooms, medical examiner's office, pediatric clinics, HIV counseling and testing sites, family planning clinics, prenatal/obstetrics clinics, and tuberculosis clinics. These examples are guidelines for data abstraction and are not exhaustive of all possible facility types. A pull-down menu of facility types is provided in the computer software and an appendix of codes is attached.

SECTION V: PATIENT/MATERNAL HISTORY

This section collects information on the presumed modes by which the patient acquired his/her infection. Only risks occurring after 1977 and before the diagnosis of HIV or AIDS should be collected. This section may be updated any time additional risk information is obtained. Information on the child refers to exposures which were felt to have exposed the child to HIV, not to treatments since he/she became HIV-infected. If the child received a blood transfusion after the documentation of HIV infection, do **NOT** enter that information on the form.

Please alert state/city NIR coordinator for suspected cases of unusual transmission circumstances. The state or local NIR coordinator should contact the CDC NIR coordinator as soon as possible if any unusual transmission circumstances are suspected.

RESPOND TO ALL CATEGORIES:

- Child's biologic mother has been diagnosed as having AIDS or documented HIV infection:

  Check the appropriate response.

If YES, mother was diagnosed before child's birth

If NO, mother was known to be uninfected after the child's birth

Check the appropriate response.

If the biologic mother has been tested for HIV and found to be uninfected at or after the child's birth then perinatal transmission is not the presumed mode of exposure to HIV infection. If mother-to-infant transmission through breastfeeding is considered as the mode of transmission, please alert the state or local NIR coordinator and enter into the field labeled "other" in the patient/maternal history section.

AFTER 1977, THIS CHILD'S BIOLOGIC MOTHER HAD:

- Injected nonprescription drugs

- HETEROSEXUAL relations with any of the following:
  - -Intravenous or injection drug user
  - -Bisexual male
  - -Male with hemophilia or coagulation disorder
  - -Transfusion recipient with documented HIV infection
  - -Transplant recipient with documented HIV infection
  - -Male with AIDS or documented HIV infection, risk not specified

    This category should only be checked if the heterosexual partner is known to be HIV positive, but their risk for HIV is unknown.

- Received transfusion of blood/blood components (other than clotting factor)

  If yes, specify the month and year of the first and last transfusions before the patient's biologic mother was infected with HIV or diagnosed with AIDS.

- Received transplant of tissue or organs or artificial insemination

  If this is the only risk history and the biologic mother was not known to be HIV infected at the time of the child's birth, the transmission mode will be initially

classified as 'undetermined' pending outcome of the risk not identified/reported (NIR) investigation. Please alert state/city NIR coordinator. If the biologic mother is known to be HIV infected and this is the only maternal risk then the case will be initially classified as 'mother has HIV infection, risk not specified'.

BEFORE THE DIAGNOSIS OF HIV INFECTION/AIDS, THIS CHILD HAD:

- Received clotting factor for hemophilia/coagulation disorder

  If yes, specify the disorder.

- Received transfusion of blood/blood components (other than clotting factor)

  If yes, specify the month and year of the first and last transfusions before the patient was infected with HIV or diagnosed with AIDS.

- Received transplant of tissue/organs

  If this is the only risk history, the transmission mode will be initially classified as 'undetermined' pending outcome of the risk not identified/reported (NIR) investigation. Alert state/city NIR coordinator.

- Sexual contact with a male

  If this is the only risk history, the transmission mode will be initially classified as 'undetermined' pending outcome of the risk not identified/reported (NIR) investigation. Alert state/city NIR coordinator.

- Sexual contact with a female

  If this is the only risk history, the transmission mode will be initially classified as 'undetermined' pending outcome of the risk not identified/reported (NIR) investigation. Alert state/city NIR coordinator.

- Injected nonprescription drugs

  If this is the only risk history, the transmission mode will be initially classified as

'other/undetermined' pending outcome of the risk not identified/reported (NIR) investigation. Alert state/city NIR coordinator.

- Other

  This category includes suspected cases of transmission due to breastfeeding or if an unusual transmission circumstance is suspected. Please alert your state or local or NIR coordinator.

SECTION VI: STATE/LOCAL USE ONLY: Physician Identifier Information

Physician identifier information is for state/local health department use only and is not transferred to CDC.

PHYSICIAN'S NAME

For reports of perinatal HIV exposure with indeterminate HIV infection status, enter the name of the physician who first considered the diagnosis of HIV infection, either clinically or through laboratory evaluation. For confirmed HIV infection reports, enter the name of the physician ordering the confirmatory test. For AIDS case reports, enter the name of the physician providing medical management to the patient. If the test was provided as part of a visit to a health department clinic, HIV counseling and testing site, or other facility where no single individual is responsible for medical management of the patient, leave this space blank and complete the "Facility of Diagnosis" section appropriately.

PHONE NO.

Enter the telephone number of the physician named above. If no physician is named, enter the phone number of the facility where the report originated.

MEDICAL RECORD NO.

Enter the medical record number if a patient has been hospitalized as an inpatient or treated as an outpatient in a hospital, community health center, or health department clinic. If the patient has both inpatient and outpatient records at the same facility, the number of the primary record should be recorded in this section. Any additional medical record numbers can be noted in the "comments" section.

HOSPITAL/FACILITY

Enter the name of the hospital or clinic where the report originated. If this report is generated from a laboratory report of HIV infection, the laboratory slip should contain the name of the facility where the specimen was collected. The software will include fields for recording the name and location of laboratory facilities for states wishing to use this information for surveillance tracking purposes. The name and location of laboratory facilities can be noted in the "comments" section.

PERSON COMPLETING FORM

Enter the name of the person who completed the form or the name of a person who can be contacted to clarify entries and supply additional medical or locating information on the patient.

PHONE NO.

Enter the telephone number of the person completing the form.

SECTION VII: LABORATORY DATA

The software allows for the collection of up to nine different laboratory test results with dates, for HIV-1 or HIV-1/HIV-2 combination EIA, HIV-1 Western blot/IFA, other HIV-1 antibody tests, positive HIV detection tests, and CD4 counts and percents.

1. *HIV ANTIBODY TESTS AT DIAGNOSIS:*

INDICATE FIRST TEST AT CURRENT DIAGNOSTIC STATUS

If perinatal HIV exposure with indeterminate HIV infection status is being reported, indicate the results and test dates for the first HIV antibody tests performed.

If confirmed HIV infection is being reported, indicate the results and test date for HIV antibody tests performed at diagnosis of HIV infection.

If an AIDS case is being reported, indicate the results and test date for HIV antibody tests performed at diagnosis of AIDS.

For a child being reported as a seroreverter, enter the first documented negative HIV antibody test after 6 months of age, if all subsequent HIV tests of any kind are negative.

- HIV-1 EIA

  Indicate the result of the first HIV-1 EIA which was recorded at current diagnostic status (i.e., perinatal HIV exposure with indeterminate infection status, confirmed HIV infection [not AIDS], AIDS, or seroreverter). Positive EIA designates repeatedly reactive tests on a single sample. Enter the month and year of test. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year. If both year and month are unknown, enter "99/99".

- HIV-1/HIV-2 combination EIA

Indicate the result of the first HIV-1/HIV-2 combination EIA test at current diagnostic status (i.e., perinatal HIV exposure with indeterminate infection status, confirmed HIV infection [not AIDS], AIDS, or seroreverter). Positive HIV-1/HIV-2 combination test designates repeatedly reactive tests on a single sample. Enter the month and year of test. If a year is present without a designated month, "99" should be

entered as the month, followed by the documented year. If both year and month are unknown, enter "99/99".

- HIV-1 Western blot/IFA

Indicate the result of the first HIV-1 Western blot/IFA which was recorded at current diagnostic status (i.e., perinatal HIV exposure with indeterminate infection status, confirmed HIV infection [not AIDS], AIDS). Enter the month and year of the test. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year. If both year and month are unknown, enter "99/99".

- Other HIV-1 antibody test

If another HIV-1 antibody test was conducted, specify the type of test performed. Indicate the result. Enter the month and year of the test. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year. If both year and month are unknown, enter "99/99".

- HIV-2 EIA

Enter the results of the first test. Enter the month and year of the test. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year.

- HIV-2 Western blot

Enter the result of the first test. Enter the month and year of the test. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year.

2. *POSITIVE HIV DETECTION TEST*

INDICATE EARLIEST POSITIVE TEST

Enter the month and year of the earliest positive detection tests (e.g., culture, antigen, PCR, DNA or RNA probe) performed. Enter the month and year of the

test. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year.

3. *IMMUNOLOGIC LAB TESTS*

AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS

- CD4 COUNT

Record the CD4 count at or closest to the current diagnostic status (i.e., perinatal HIV exposure with indeterminate infection status, confirmed HIV infection [not AIDS], AIDS, or seroreverter). If this information is not available when the initial case report is completed, it may be entered later. For reports of perinatal HIV exposure with indeterminate infection status, record the CD4 count at or closest to the time the patient was first evaluated for HIV infection. For confirmed HIV infection reports, record the CD4 count at or closest to the time the patient is determined to be HIV-infected. For AIDS reports, record the CD4 count at or closest to the time that an AIDS-defining clinical condition was diagnosed. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year.

- CD4 PERCENT

Record the CD4 percent which corresponds to the CD4 count recorded above. If no CD4 count is available, record the CD4 percent at or closest to, the current diagnostic status (i.e., perinatal HIV exposure with indeterminate HIV infection status, confirmed HIV infection [not AIDS], AIDS, or seroreverter). If this information is not available when the initial case report is completed it may be entered later. For reports of perinatal HIV exposure with indeterminate infection status, record the CD4 percent at or closest to the time the patient was first evaluated for HIV infection. For confirmed HIV infection reports, record the CD4 percent at or closest to the time the patient is determined to be HIV-infected. For AIDS reports, record the CD4 percent at or closest to the time that an AIDS-defining clinical condition was diagnosed. If a year is present without a

designated month, "99" should be entered as the month, followed by the documented year.

FOR AIDS CASES PRESUMPTIVELY DIAGNOSED < 15 MONTHS OF AGE

RESPOND TO ALL CATEGORIES:

Under the 1987 pediatric AIDS case definition conditions such as recurrent bacterial infections or presumptively diagnosed candidiasis of the esophagus require documentation of HIV infection to be considered HIV-related (see 1987 pediatric AIDS case definition, appendix A). For a child born to an HIV-infected mother who was diagnosed with AIDS at less then 15 months of age, record the laboratory test results (lowest or highest as indicated) which were done at < 15 months of age.

- Lymphocyte count < 1000/μL

  Check the appropriate response.

- CD4/CD8 ratio < 1.0

  Check the appropriate response.

- Total serum immunoglobulins **(HIGHEST)**

  Check the appropriate response.

4. *IF HIV TESTS WERE NOT POSITIVE OR WERE NOT DONE: DOES THIS PATIENT HAVE AN IMMUNODEFICIENCY THAT WOULD DISQUALIFY HIM/HER FROM THE AIDS CASE DEFINITION?*

Check the appropriate response. Causes of immunodeficiency that disqualify clinical conditions as indicators of AIDS in the absence of laboratory evidence for HIV infection are:

1. High-dose or long-term systemic corticosteroid therapy or other immunosuppressive/cytotoxic therapy within 3 months before the onset of the AIDS-defining clinical condition.

2. Any of the following diseases diagnosed before or within 3 months after the AIDS-defining clinical condition was diagnosed: Hodgkin's disease, non-Hodgkin's lymphoma (other than primary brain lymphoma), lymphocytic leukemia, multiple myeloma, any other cancer of lymphoreticular or histiocytic tissue, or angioimmunoblastic lymphadenopathy.

3. A genetic (congenital) immunodeficiency syndrome or an acquired immunodeficiency syndrome atypical of HIV infection, such as one involving hypogammaglobulinemia.

5. *IF LABORATORY TESTS WERE NOT DOCUMENTED, IS PATIENT CONFIRMED TO BE HIV INFECTED BY A PHYSICIAN?*

Check the appropriate response.

A physician diagnosis is made by clinical or laboratory evidence of confirmed HIV infection. Documentation by a physician of HIV infection by parent/guardian or patient self report/history is not considered a 'physician diagnosis'.

IF YES, PROVIDE DATE OF DOCUMENTATION BY PHYSICIAN.

If laboratory evidence of confirmed HIV infection is unavailable in the patient's medical or other record and written documentation of an HIV confirmatory test is noted by the physician, enter the date of documentation of confirmed HIV infection by a physician. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year. The software will not allow entry of "99" for unknown year.

SECTION VIII: CLINICAL STATUS

CLINICAL RECORD REVIEWED

Check the appropriate response.

CLINICAL STATUS AT LAST EVALUATION:

ASYMPTOMATIC

If there is documentation that at last clinical evaluation the patient had no signs or symptoms thought secondary to HIV infection, enter the last date of clinical evaluation. This category includes children with confirmed HIV infection and children born to HIV- infected mothers who do not meet the criteria for confirmed HIV infection and have no "HIV-related" symptoms. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year. The software will not allow entry of "99" for unknown year.

SYMPTOMATIC (HIV-related, not AIDS)

If there is documentation that at last clinical evaluation the patient had signs or symptoms related to HIV infection but did not meet the 1987 AIDS case definition, enter date of evaluation. A child that has had signs or symptoms related to HIV infection documented in the past but is currently asymptomatic should be classified as symptomatic and the date at most recent evaluation for HIV-related signs or symptoms should be entered. This category includes children with confirmed HIV infection and children born to HIV infected mothers who do not meet the criteria for confirmed HIV infection and have HIV-related signs or symptoms (not AIDS). Clinical conditions that are considered "HIV-related" are listed under Class P-2, not AIDS, in the 1987 Classification System for Human Immunodeficiency Virus (HIV) Infection in Children Under 13 Years of Age (Appendix B) or, any clinical condition that a physician documents to be "HIV-related". For example, a child with hepatitis secondary to Hepatitis B virus is not considered under Class P-2 because the hepatitis was not due to HIV. If a year is present without a designated month, "99" should be entered as the month, followed by the documented year. The software will not allow entry of "99" for unknown year.

AIDS INDICATOR DISEASES

Check all AIDS indicator diseases that apply and enter dates of diagnosis. Enter the dates of initial diagnosis of each indicator disease. If a year is present without a designated month, "99" should be entered as the month followed by the documented year. The software will not allow entry of "99" for unknown year.

Definitive diagnoses are based on specific laboratory methods such as histology or culture. These methods are detailed in the 1987 case definition (*MMWR* 1987:36:1-15S) (see appendix).

Presumptive diagnoses are made by the clinician. The methods of diagnosis listed in the case definition are guidelines only, and any method that the clinician considers diagnostic should be accepted.

HAS THIS CHILD BEEN DIAGNOSED WITH PULMONARY TUBERCULOSIS?

Check the appropriate box. The definitive diagnostic method for tuberculosis is culture. For presumptive diagnosis when bacteriologic confirmation is not available, other reports may be considered to be verified cases of pulmonary tuberculosis if the criteria of the Division of Tuberculosis Elimination, National Center for Prevention Services, CDC are used. The criteria in use are available in Case Definitions for Public Health Surveillance (*MMWR* 1990;39(No.RR-13):39-40.

If yes, check the appropriate box (definitive or presumptive diagnosis) and provide the month and year of diagnosis. If a year is present without a designated month, "99" should be entered as the month followed by the documented year. The software will not allow entry of "99" for unknown year; it will interpret such an entry as the year 1999.

RVCT Case No.

If this patient is a verified pulmonary tuberculosis case, enter the nine-digit alphanumeric code from the case report. **To be completed by state/local health depart ment.**

SECTION IX: BIRTH HISTORY (FOR PERINATAL CASES ONLY)

BIRTH HISTORY WAS AVAILABLE FOR THIS CHILD

Check appropriate response. If birth history was not available or unknown, proceed to Section X.

HOSPITAL AT BIRTH

Enter the name, city, state, country and zip code of the hospital or clinic at birth. Sites should make sure that hospital names are standardized, including abbreviations. If the child was born at home, enter "Home Birth" as the hospital name. If unknown, enter "Unknown". Do not leave blank.

RESIDENCE AT BIRTH

Enter the city, county, state, country and zip code of residence of the patient at the time of delivery. If unknown, enter "Unknown". Do not leave blank.

BIRTHWEIGHT

Enter the birth weight in either pounds and ounces or grams. If unknown, enter "99999".

TYPE

Check the appropriate response. If unknown, enter "9".

DELIVERY

Check appropriate response. If unknown, enter "9". Notes in the child's records are acceptable even if no birth records are available.

NEONATAL STATUS

Check the appropriate response. "Full Term" is defined as greater than or equal to 37 weeks gestation. "Premature" is defined as less than 37 weeks gestation. Enter number of weeks gestation. If unknown, enter "99".

STATE/LOCAL HEALTH DEPARTMENT TO COMPLETE THE SHADED AREA:

MATERNAL DATE OF BIRTH

Enter the biologic mother's month, day and year of birth.

MATERNAL SOUNDEX

To be completed by state/local health department personnel. (In accordance with local laws). If the biologic mother has been entered in your current HARS database and a *stateno* exists, retrieve the soundex code from the database and enter here. If the biologic mother has not been entered in the database, enter the name and date of birth information in the HARS software. The biologic mother's surname will be converted to a Soundex code when entered into the HARS software. Identifiers collected in this section are not transmitted to CDC.

MATERNAL STATE PATIENT NO.

To be completed by state/local health department personnel. (In accordance with local laws). Enter the assigned maternal state patient number if the biologic mother is known to be HIV infected. **State numbers must not be reused.**

BIRTHPLACE OF BIOLOGIC MOTHER

Place a "√" in the box corresponding to the biologic mother's country of birth. If this information is not available from the child's records, it can be left blank and updated on follow-up. U.S.dependencies, possessions and independent nations are Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Republic of Palau, the Republic of the Marshall Islands, the Commonwealth of the Northern Manana Islands, and the Federated States of Micronesia.

SECTION X: TREATMENT/SERVICES REFERRALS

This section should be initially completed by the person notifying the health department of the HIV/AIDS patient. This information should be updated for each

child when there is a change in diagnostic status, whenever possible. **Some questions in this section will only apply to patients in states where HIV surveillance is conducted.**

- *This patient received or is receiving:*

  Anti-retroviral therapy (e.g., AZT, DDI [dideoxyinosine], DDC [dideoxycytidine])

  Check the appropriate box.

  PCP prophylaxis (e.g., TMP-SMX [Trimethoprim-Sulfamethoxazole, Bactrim, Septra], pentamidine, dapsone).

  Check the appropriate box. See CDC Guidelines for Prophylaxis Against *Pneumocystis carinii* Pneumonia for Children Infected with Human Immunodeficiency Virus (See appendix D). Mark Yes if the patient has received or is receiving these medications over a prolonged period for PCP prophylaxis. For example, treatment with TMP-SMX (Septra, Bactrim) for two to three weeks for otitis media would not be coded here.

  IVIG therapy (intravenous immune globulin).

  Check the appropriate box.

- *This patient has been enrolled at*

  Clinical Trial:

  Check the appropriate box.

  Clinic:

  Check the appropriate box.

- *This patient's medical treatment is PRIMARILY reimbursed through:*

  Check the appropriate box.

  Medicaid reimbursement means specifically Medicaid. State Crippled Children's Services, would be "Other Public Funding". HRSA Pediatric AIDS demonstration

project, would be "Clinical Trial/government program". See face sheet of the medical record for this information, where possible.

- *This child's PRIMARY caretaker is:*

  Check the box corresponding to the persons who give the majority of care for the child. "Other relative" refers to children living with an aunt, grandmother, etc, in an informal arrangement and the relative does not receive a stipend for providing care. Foster parent, relative refers to children in kinship foster care. This means for children living with a relative such as a grandmother and the grandmother is paid a stipend for caring for this child. This type of program is not available in all places. Adoptive parent, relative refers to children who have been legally adopted by a relative. If the foster/adoptive parent is unrelated please check "Foster/Adoptive parent, unrelated". "Social Service Agency" refers to children whose primary caretaker is a social service agency, which usually refers to children living in group home situations.

- *This child/family has been referred for social service support:*

  Check the appropriate response.

SECTION XI: COMMENTS

This section can be used for information not requested on the form. DO NOT place identifying information in the corresponding section of the HARS software.

STATEMENT OF PUBLIC BURDEN:

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing

data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to PHS Reports Clearance Officer; ATTN: PRA; Hubert H. Humphrey Building; Room 721-B; 300 Independence Avenue, SW; Washington, D.C. 20201, and to the Office of Management and Budget; Paperwork Reduction Project (0920-0009); Washington, D.C. 20503.

DO NOT USE SPACE BELOW

COMMONWEALTH OF VIRGINIA-DEPARTMENT OF GENERAL SERVICES
DIVISION OF CONSOLIDATED LABORATORY SERVICES-BUREAU OF ANALYTICAL SERVICES
SEROLOGIC TESTS FOR SYPHILIS

DATE REC'D _____

NON-TREPONEMAL TESTS

VDRL	RPR
☐ NON-REACTIVE	☐ NON-REACTIVE
☐ WEAKLY REACTIVE	
☐ REACTIVE	☐ REACTIVE
TITER _____	TITER _____

TREPONEMAL TESTS

TP-PA	FTA-ABS
☐ NON-REACTIVE	☐ NON-REACTIVE
☐ REACTIVE	☐ REACTIVE
☐ INCONCLUSIVE *	☐ INCONCLUSIVE*
	☐ REACTIVE MINIMAL*

*THIS IS AN EQUIVOCAL RESULT
PLEASE SUBMIT ANOTHER SPECIMEN
IF INDICATED

☐ UNSATISFACTORY

COMMENTS _____

_____

DATE REPORTED _____

PATIENT _____

ADDRESS _____

SSN _____ RACE ___ SEX ___ MARRIED ____ AGE ____

DOB _____ DATE COLLECTED _____

SPECIMEN TYPE	PURPOSE FOR TESTING	
☐ WHOLE BLOOD	☐ SUSPICIOUS LESION	☐ SCREENING
☐ SERUM	☐ DIAGNOSIS	☐ PRENATAL
☐ SPINAL FLUID	☐ TREATMENT	☐ RETEST
☐ PLASMA	☐ TREPONEMAL TEST	☐ OTHER
	☐ CONTACT WITH KNOWN CASE	

SUBMITTER _____

ADDRESS _____

CITY _____ VIRGINIA ZIP CODE _____

SUBMITTER

DCLS# _____

DGS-22-059 (REV. 5/00)

Quality Assurance Plan

A quality assurance (QA) program is an effective means to ensure that excellent patient services and care are being provided. A QA program is critical to not only quality of care provided, but standards and criteria, budget allocations, staffing patterns, clinic flow, and program planning. While useful in identifying trends in the quality of clinical care, the chart audit alone does not give a complete picture of clinical operations. Multiple methods, including direct observation of performance and proficiency testing, are needed to arrive at valid determinations.

Quality assurance is best accomplished through an interdisciplinary, or"team" approach, which includes a QA committee composed of representatives from each of the disciplines present in an std clinic including data processing if the QA program involves computerization. An outside QA expert may assist the group in designing study criteria. This team approach may contribute toward employee development, and enhance staff morale. Communication among the staff through a discussion of issues is a key element.

A QA program should evaluate all aspects of the clinic operation, clinical as well as non-clinical. Nonclinical issues that should be evaluated may include:

1. Patient flow analysis
2. Patient waiting time
3. Number of patient stops during visit
4. Number of patient "turn-aways" in a specified time-frame
5. Patient satisfaction surveys
6. Staffing patterns
7. Number of patients seen per clinician/day/gender

Quality Assurance Cycle

1. Selection of review criteria: Review criteria are selected by the QA committee to permit objective review of the quality of patient services. Criteria must be precise enough to permit accuracy and objectivity. (See: Sample Quality Assurance Review Criteria - Form 1). Each of the criteria consists of four parts:
   a. An element which is an expected goal or procedure.
   b. Responsibility for its execution or completion.
   c. A standard of percentage which is the number of times the element is expected to be met in percentage.
   d. Exceptions which is any justifiable non-conformance to the element. An exception is not necessary in every criterion.

2. Chart retrieval: A random sample of charts should be pulled which will ensure a true representation of clinic activity. Additionally, random sampling encourages good clinical practice. Charts may be divided equally between male and female patients.

Ten charts per week can be selected for a total of 40, to be reviewed at a monthly meeting.

3. Independent chart review: Prior to the regularly scheduled meeting, each QA committee member reviews these charts in comparison to the review criteria, and briefly notes findings on a QA committee report (see: sample QA committee report - form 2). These observations are compared among the respective members of the committee at the QA meeting.

4. QA committee meeting: Members of the committee present their findings of variations from the established standards found in each respective chart. The QA committee chairperson records the findings on a QA committee report (form 2). If the committee agrees that there is no justification for the variation, then they must establish why the variation occurred.

5. Determine corrective action: The committee' s goal now is to select the appropriate action to solve the problem. The clinic manager has overall responsibility to ensure that corrective action is implemented. Each deficiency should be addressed and corrected by the director into whose discipline the variation falls. For correction of variations to be most effective, feedback should be immediate. The deficiencies and corrective actions can be in the areas of knowledge, environment, or feedback. Deficiencies in knowledge may require a solution of further education directed to the staff, such as in-service programs, further orientation, or demonstration. Deficiencies in environment may require a restructuring to reduce interference, rearrangement of tasks or clinic flow, or providing needed tools. Deficiencies in feedback may simply require discussions to clarify a function.

6. Evaluation of corrective action: The committee' s next goal is to determine if the action corrected the problem. Progress toward correction of the variation should be discussed at subsequent meetings. This can be accomplished by close scrutiny of charts in a time frame after the corrective action was implemented. If similar deficiencies are noted again, the committee must reevaluate the problem and implement a new corrective action plan.

7. Reporting: The QA committee may present its findings in a quarterly report to the health commissioner, or to whomever else the committee is so directed.

Computer-Based Quality Assurance

Those clinics with computer capability can simplify the QA process and reduce the time required to perform meaningful analysis. Once the QA committee establishes review criteria and the key elements of each are determined, computer printouts can be generated directly from selected fields comprising the computerized medical record format.

Examples of review criteria may include:

1. Correlation between gonorrhea gram stains and cultures among male patients who present with urethral discharges
2. Expand this analysis by correlating these findings with the clinician and/or the laboratorian handling, preparing, and reading the specimen.
3. Expand the analysis further by comparing these findings to overall clinic sensitivity ratios
4. Analysis of intertechnician variability in reading gram stains, darkfields, and wet preps when compared to an overall clinic sensitivity ratio
5. Correlation among patients presenting with genital lesions and whether an rpr and darkfield were ordered
6. Correlation between laboratory supported diagnosis and the administration of recommended therapy

The committee can create review criteria according to the needs of the clinic, the actual and perceived problems existing in the clinic, and the limitations placed on the committee by the capabilities of the computer-based medical records system.

Form 1
Sample Quality Assurance Review Criteria

This sample form can be used by committee members performing chart review when lack of computers necessitates hand tallies.

Reviewer_____ chart number_____

	1	2	3
1. Confidential intake/registration form: (clerical responsibility)			
a. Completed	/	/	
b. If patient refuses, documented and referred to DIS	/	/	
c. If more than 2 weeks pass between visits, new form appears	/	/	
2. Informed consent: (clerical responsibility)			
a. Completed	/	/	
b. If patient refuses, documented and referred to dis	/	/	
3. Expected in file: (clerical responsibility)			
a. File checked	/	/	
b. If contact, cluster suspect or associate, reactor or positive culture, documented in "reason for visit" section	/	/	
4. Reason for visit: (clinician responsibility)			
a. Completed	/	/	
note: there may be more than one reason for visit			
5. Medical history section: (clinician responsibility)			
a. Completed	/	/	
b. Previous STD/HIV tests results and dates documented	/	/	
c. Injection drug user, referred for tuberculosis skin test	/	/	

	1	2	3
d. Based on documented allergies, no contraindication medications prescribed (e.g., penicillin allergy should be stamped in red)	/	/	
e. If currently pregnant, no contraindicated medications prescribed (e.g., tetracyclines)	/	/	
6. Physical examination: (clinician responsibility)			
a. Completed	/	/	
b. laboratory tests ordered match present symptoms or reason for visit (e.g., If lesion is present, darkfield was ordered)	/	/	
c. Anatomical sites tested correlates with documented exposure sites	/	/	
d. Bimanual examination performed on all female patients	/	/	
e. Site specific and/or generalized lymphadenopathy documented	/	/	
f. Hepatitis B referral made if indicated (e.g., gay and bisexual men, persons with multiple sex partners, injection drug users)	/	/	
7. Laboratory results: (laboratorian responsibility if stat test; clerical responsibility if from reference laboratory)			
a. Documented	/	/	
b. Gram stain results correlate with gonorrhea culture	/	/	
c. Nontreponemal test tittered to end point	/	/	
d. Correlation of stat nontreponemal tests with all lesion cases)	/	/	
8. Diagnosis and treatment: (clinician responsibility)			
a. Documented	/	/	
b. Diagnosis correlates with laboratory and clinical findings	/	/	
c. treatment correlates with diagnosis	/	/	

	1	2	3
d. Type and amount of treatment correlates with clinic treatment protocol	/	/	
e. Epidemiological treatment administered (contacts to: early syphilis, gonorrhea, pid, chlamydia; selected suspects and associates on early syphilis cases)	/	/	
f. Date and reason for reevaluatoin documented	/	/	
g. If appropriate, patient referred to community support services (e.g., Hiv positive patients, drug treatment , family planning)	/	/	
9. Counseling: (clinician responsibility)			
a. Performed	/	/	
b. Hiv pretest and posttest counseling offered to all patients unless there is documentation of a nonreactive test within the previous 90 days or previous reactive (in the absence of a recent exposure)	/	/	
c. Importance of examination of sex partners discussed (clinician provides self-referral cards to patient)	/	/	
d. Condoms offered	/	/	
10. Referral to DIS: (clinician responsibility)			
a. Documented if referral is indicated (e.g., early syphilis)	/	/	
11. Chart signed: (clinician responsibility)			
a. Signed and dated	/	/	

Form 2
Sample Quality Assurance Committee Report

Date: June 15, 1993

Patient: John C. Smith Reviewer: William Jones, Clinic Manager

Chart Number: 14367-A

Synopsis: 24 year old, black male, presented with penile discharge x three days

Findings: Reason for visit not documented. No evidence of penicillin allergy or other antibiotic allergy documented. Patient had penile discharge x three days but no gram stain was ordered. Patient indicated rectal exposure but no rectal gonorrhea culture was ordered. Chart not signed by examining clinician.

Date: June 16, 1993

Patient: Tom Wilson Reviewer: William Jones, Clinic Manager

Chart Number: 14522-A

Synopsis: 35 year old, white male, who presented without symptoms. Stated his reason for wanting examination was "VD checkup."

Findings: Patient stated he had syphilis in 1988, but place of treatment, and test results not addressed. Patient indicated long-term injection drug use, but pre- and post-test HIV counseling was not offered, nor was referral to appropriate community support service offered. Chart was not signed by clinician.

Date: June 16, 1993

Patient: Mary Brown Reviewer: William Jones, Clinic Manager

Chart Number: 14599-A

Synopsis: 19 year old, black female, presented with lower abdominal pain and backache x five days; low grade fever x 4 days; nausea and vomiting x three days.

Findings: Patient complained of lower abdominal pain x five days, and low grade fever of 100°f x four days, yet no endocervical gonorrhea culture was ordered. Diagnosis was UTI (urinary tract infection); Bactrim prescribed. No informed consent was found in chart.

VIRGINIA DEPARTMENT OF HEALTH
Division of STD/AIDS
STD/HIV Skills Inventory

ealth Counselor: _____ Work Area: _____

ISTDI Instructor: _____ Course Dates: _____

This is the 1st_____ 2nd_____ 3rd_____ other_____ inventory since the course.

Period Covered by this Skills Inventory: _____/_____ to _____/_____ of 19_____.

Firstline Supervisor: _____ Date Completed: _____

Level 1 Manager: _____ Date Completed: _____

STD/HIV INTERVIEWING SKILLS INVENTORY

This inventory is based on the observation of _____ interviews.
How consistently well does the health counselor perform in the following areas?

***All areas are rated based on the following:**
5 = Exceptional 4 = Exceeds Expectations 3 = Meets Expectations
2 = Fair but Needs Improvement 1 = Doesn't Meet Expectations

COMMUNICATION

_____ 1. Demonstrates professionalism
_____ 2. Establishes rapport
_____ 3. Listens effectively
_____ 4. Uses open-ended questions
_____ 5. Communicates at the patient's level of understanding
_____ 6. Gives factual information
_____ 7. Solicits patient feedback
_____ 8. Uses reinforcement
_____ 9. Uses appropriate nonverbal communication

PROBLEM SOLVING

_____ 10. Recognizes verbal problem indicators
_____ 11. Recognizes nonverbal problem indicators
_____ 12. Verifies the meaning of recognized problem indicators
_____ 13. Assertively confronts problems communicated by patients
_____ 14. Resolves patient problems
_____ 15. Uses STD/HIV motivators
_____ 16. Motivates clearly and convincingly
_____ 17. Emphasizes confidentiality

ANALYTICAL CAPABILITIES

_____ 18. Computes and uses interview periods
_____ 19. Recognizes exposure
_____ 20. Determines accurate source relationship
_____ 21. Determines investigative priorities
_____ 22. Recognizes discrepancies in patient responses

DISEASE INTERVENTION BEHAVIORS

_____ 23. Emphasizes sex partner referral and establishes plan to notify partners
_____ 24. Tactfully persists to identify all at-risk sex partners
_____ 25. Pursues detailed locating/identifying information on sex partners
_____ 26. Emphasizes other disease intervention behaviors as appropriate to the patient
_____ 27. Conveys a sense of urgency
_____ 28. Establishes specific contacts and coaches patients
_____ 29. Pursues timely reinterviews with a plan

HIV DISEASE INTERVENTION

_____ 30. Explains confidentiality and authorized disclosures
_____ 31. Identifies patient's risk factors
_____ 32. Describes the benefits of HIV testing
_____ 33. Describes the testing procedures
_____ 34. Assesses last exposure data and needs for retesting
_____ 35. Describes test result impact on client's lifestyle/future behavior
_____ 36. Describes the the meaning of positive and negative test results
_____ 37. Assists patients in developing a personalized risk reduction plan
_____ 38. Make appropriate medical, mental health, and social support referrals

FIELD ACTIVITIES

is inventory is based on the observation of field
vestigations of _____ persons on _____days.

_____ 39. Assume the responsibility for the ultimate success of assigned investigations, regardless of coworker participation In the referral process and take prompt action
_____ 40. Utilize resources effectively in planning and executing referrals
_____ 41. Recognize investigative priorities
_____ 42. Select appropriate referral methods
_____ 43. Take promt initial action on priority investigations and prompt follow up when a person defaults on a referral
_____ 44. Demonstrate timely, persistent, and imaginative action required to move a stalled investigation
_____ 45. Demonstrate discretion and judgement in the use of the telephone as an investigative tool
_____ 46. Confidentially and professionally manage circumstances which are obstacles in any investigation
_____ 47. Explain why patient identities are kept confidential and recommend discussing risk with their own partners as appropriate
____ 48. Motivate people to come in promptly
____ 49. Document the investigative activities completely and accurately according to program protocol

:UPERVISOR COMMENTS:

SUPERVISOR COMMENTS

PROGRAM FOR EXCELLENCE REVIEW
SUMMARY OF REVIEW PROCESS
FOR STD/AIDS PROGRAM

Background: The purpose of the Program for Excellence (PFE) review is to provide the management of district health offices a program-specific self-evaluation tool. The review is a collaborative activity between designated reviewers and the district health office. Evaluation modules include Health Care Services, Environmental Health Services, Management and Support Services, Pharmacy Services, and Laboratory Support Services. The STD/AIDS program is reviewed as part of the Health Services Modules. (See PFE manual for specific components of each module.)

The STD/AIDS program, like other programs, is evaluated on the basis of four principles: Health Status monitoring, Service Availability and Accessibility, Resource Utilization, and Quality of Services. Evaluation takes place through completion of pre-site visit data sheets, observations of direct patient services, record reviews, and interviews with staff, patients, and health care providers in the community. Information from the evaluation is discussed at the exit interview, followed by a written report. Corrective actions are planned and implemented based on recommendations in the report.

I. Preparation for PFE Review of STD/AIDS Program

A. Have program coordinator/manager attend the scheduled PFE Orientation Program.

B. Determine who will be responsible for pre-site visit activities and on-site review activities.

C. Complete pre-site review data sheets (to be sent to evaluators one month prior to review).

Statistical information may be obtained from the Bureau of STD/AIDS, Statistics/Data Management office.

D. Develop schedule for on-site review, to include:

1. Introductory conference with program reviewers and STD program coordinator/manager.
2. Observations in STD clinics.
3. Observations in HIV testing clinic if separate from STD clinic.
4. Interview with STD clinic staff.
5. Interview with disease intervention specialists (Epi Reps.).
6. Field visits with disease intervention specialists.

7. Interviews with hospital infection control staff (may be coordinated with review of reporting for other communicable diseases).

E. Submit local protocols for STD/AIDS services to reviewers.

Pre-site data should be submitted to the evaluation team one month before the review.

F. Prepare staff for PFE review two weeks prior to on-site visit by evaluation team.

1. Review purpose of PFE review.
2. Review criteria for evaluation of clinical services.

G. Prepare for clinical record review one week prior to on-site visit by evaluation team.

1. Pull STD records for review - random selection, 20-25 (open and closed) records or per request of reviewers.
2. Provide State AIDS Medication Program records for review.
3. Pull epidemiology records (STD case investigation records) for time period determined by the reviewers.
4. Schedule quiet room for record review.

H. Schedule exit interview with STD reviewers.

II. Program Review

A. Introduction to STD/AIDS program

Meet with program coordinator/manager to provide overview of STD/AIDS Program to reviewers.

B. Clinic Observation/Patient Survey

1. Have supervisor/charge nurse provide reviewers a description of clinic flow.
2. Remind staff to obtain verbal permission from patients for clinic observation.

C. STD epidemiology

1. Epi record review - have designated records for cases investigated in designated time period.

2. Interview with disease intervention specialists - discussion to include: workload, case management , supervision, links with community health care providers.
3. Field visits - reviewer will accompany Epi Reps to evaluate organization of work, interactions with clients and providers, and approaches to investigation of cases/contacts.

D. Clinical Record Review.

1. Have STD records and State Medication Program records available to reviewer.
2. Assure coordinator/supervisor is available to answer questions.

E. Hospital Infection Control Visits: Have STD coordinator or Infection Control Nurse Manager accompany reviewer.

III. Exit Interview

A. Reviewers will give a summary of findings (strengths, weaknesses, and recommendations) at the exit interview.

B. Plan for program modification can be begun after exit interview.

C. A written report summarizing findings of review will follow exit interview.

D. STD program coordinator/manager will reply with a written plan to implement recommendations as appropriate. This report should include the status of any corrective actions recommended.

District Policies

This section of the HIV/STD Operations Manual is provided so that local Health Districts may include District specific policies for their staff as appropriate.

COMMUNITY ALERT BULLETIN

National Institute on Drug Abuse 5600 Fishers Lane, Rockville, MD 20857

March 25, 1993

Dear Colleague:

Injection drug use remains a very important risk factor for the transmission of HIV. The AIDS virus can be passed from one person to another when injection paraphernalia are shared. As you know, the virus may be harbored in a variety of items used for drug injection, such as needles, syringes, cotton and "cookers." Needles and syringes, however, remain of paramount concern.

On February 9-10, 1993, the Centers for Disease Control and Prevention, the Center for Substance Abuse Treatment, and the National Institute on Drug Abuse cosponsored a meeting at Johns Hopkins University School of Hygiene and Public Health in Baltimore, Maryland. The workshop reviewed research and current practices on the use of bleach to decontaminate drug injection equipment.

Several papers in the 1980s suggested that household bleach inactivated HIV in vitro (MMWR 1982;31:577-80, Lancet 1984;2:899-900, Journal of Infectious Diseases 1985;152:400-3, and JAMA 1986;255:1887-91). In those studies, the target was cell-free virus or virus in cell culture. Bleach soon became the standard for use in needle hygiene programs, and small bottles of bleach were distributed to injecting drug users (IDUs) by outreach workers throughout the country. Bleach bottles became a point of contact with drug users out-of-treatment, and their distribution became a vehicle to provide AIDS education and a recruitment tool for drug abuse treatment.

However, more recent data have raised new questions about the efficacy of bleach cleaning. These new findings were summarized at the Baltimore meeting in February. One study found that bleach was more effective than most other readily available solutions, such as alcohol and hydrogen peroxide, but not as effective against HIV in blood as it was against HIV in a cell-free state or in cell culture (Flynn et al., Sixth International Conference on AIDS, 1990, Abstract S.C.761;3:279). Another examined the HIV seroconversion rates among a cohort of injecting drug users in Baltimore and compared those reporting use of disinfectants all the time versus those who denied ever using disinfectants to clean needles and syringes. No significant difference in HIV infection incidence between disinfectant users and nondisinfectant users was found (Vlahov et al., Epidemiology 1991;2:444-6).

Contoreggi et al., NIDA, found that a 10 percent dilution of household bleach (0.525% sodium hypochlorite) was not effective in removing blood from syringes using a 6-second cleaning with bleach, followed by two 6-second rinses with water. Clotted blood was more difficult to clean than fresh blood (VIII International Conference on AIDS, 1992, Abstract PoC 4290;2:C-291). Dr. Contoreggi also observed that bleach may initially enhance clot formation when mixed with blood, which may hinder blood removal and HIV inactivation (unpublished data). Still another study in Miami found that full-strength household bleach (5.25% sodium hypochlorite, e.g., brand name - Clorox) was an effective inactivator of pelleted HIV at exposures of 30 seconds or greater, whereas a 10 percent dilution of household bleach (0.525% sodium hypochlorite) was effective only after exposures of 2 hours [Shapshak et al., JAIDS 1993;6:218-9 (letter)]. Gleghorn et al., videotaped drug users conducting mock needle and syringe cleaning and found that more than 80 percent of 161 subjects used bleach for less than 30 seconds when cleaning syringes, although they reported cleaning for longer periods of time (unpublished data).

The sum of this research indicates that use of bleach is an imperfect approach to eradicate or inactivate HIV from injection equipment. We must continue to strengthen our efforts to help IDUs cease to use drugs. Those who do continue to inject drugs must be encouraged to never share injection equipment and be aware that the cleaning of needles and syringes between uses is an imperfect way to prevent HIV infection.

The next two pages list recommendations I would like to propose to help drug users understand how to decrease their risk of HIV infection.

Please feel free to call me at (301) 443-6480 or Dr. Harry Haverkos, Director, Office on AIDS, NIDA, at (301) 443-6697 to discuss these findings and recommendations.

Sincerely,

Richard A. Millstein

Richard A. Millstein
Acting Director

Proposed Recommendations to Prevent HIV Transmission by Sharing Drug Injection Equipment.

All drug abusers should be aware of the potential for acquiring HIV infection and AIDS from sequentially using (sharing) injection equipment and paraphernalia and through sexual activity. [NOTE: For more specific recommendations regarding sexual transmission of HIV, see MMWR 1986;35:152-5.]

Persons with a negative HIV-antibody test should be counseled to reduce their risk of acquiring HIV infection through sharing injection equipment by the following means.

- **Abstain from any further use of drugs by injection.** This eliminates any new risk of bloodborne infections. Drug abuse treatment should be sought to aid in stopping drug use.

- **Do not share injection equipment with anyone.** This further protects the drug user from contracting HIV infection Care should be taken not only with needles and syringes, but also with cotton balls, cookers, wash bottles, or any other materials possibly containing blood. [Note to Policymakers and other Public Health Officials: Review your local laws and regulations concerning needle/syringe availability and paraphernalia possession. Needle/syringe exchange programs may provide another means of providing sterile equipment to users and decreasing sequential use of injection equipment by addicts; however, the risks and benefits of such programs are still under study.]

- **If you continue to share injection equipment, disinfect between uses.** While it is not foolproof, boiling needles and syringes for 15 minutes is one way to sterilize equipment between uses; however, boiling plastic equipment may alter the shape and utility of the syringes. Cleaning injection equipment with disinfectants, such as bleach, does not guarantee that HIV is inactivated. DISINFECTANTS DO NOT STERILIZE EQUIPMENT. However, consistent and thorough cleaning of injection equipment with disinfectants such as bleach should REDUCE transmission of HIV if equipment is reused or shared.

  To maximize the effectiveness of cleaning, needles and syringes should be flushed with water, preferably soon after use, before blood has time to clot in the needle and syringe. Continue flushing until the equipment is at least visibly clear of blood and debris. The use of soapy water and agitating (tapping, shaking or "plucking") the equipment while cleaning may be helpful in removing

blood and debris. The equipment should then be FILLED with full-strength household bleach for at least 30 seconds of contact before again rinsing with water. Even apparently clean equipment should be bleached before use unless it is known to be sterile. Bleach, which is highly corrosive, may alter the usefulness of the equipment.

Infected persons should be counseled to prevent further transmission of HIV by the following means:

- **Inform prospective drug-using partners and sexual partners of his or her infection, so they can take appropriate precautions.** Clearly, abstaining from drug injection and sexual activity with another person is one option that would eliminate any risk of HIV transmission by those routes.

- **Protect a partner during any drug use by taking precautions, as suggested above.** Since reinfection and/or infection with another strain of HIV may contribute to disease progression, HIV-infected drug users should refrain from reusing or sharing injection equipment to protect their own health as well as that of others.

DEPARTMENT OF
HEALTH & HUMAN SERVICES

Public Health Service
National Institutes of Health
National Institute on Drug Abuse
Room 10A-39
Rockville, MD 20857

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration

NIDA
NATIONAL INSTITUTE ON DRUG ABUSE

Substance Abuse and Mental Health Services Administration
SAMHSA

May 9, 1997

HIV PREVENTION BULLETIN: MEDICAL ADVICE FOR PERSONS WHO INJECT ILLICIT DRUGS

Dear Colleague:

Preventing drug use and providing substance abuse treatment for persons who inject illicit drugs are crucial to preventing many blood-borne infections, including human immunodeficiency virus (HIV). However, many drug users are not currently in substance abuse treatment programs because of multiple factors including the limited availability of these programs and the lack of readiness or willingness of some drug users to enter substance abuse treatment. Consequently, substantial numbers of drug users continue to inject drugs.

This bulletin summarizes new information on preventing transmission of HIV and other blood-borne infections among persons who inject drugs and updates prevention recommendations published in April 1993. *[1] The findings of a 1995 workshop on the use of sterile syringes by persons who inject drugs and several recent publications [2,3,4,5,6] indicate that persons who inject drugs should use sterile syringes** to prevent the transmission of HIV and other blood-borne infectious diseases. These conclusions should be considered by clinicians providing health care to persons who use or inject drugs and by public health professionals planning and carrying out HIV prevention programs for injection drug users (IDUs). Health professionals should inform IDUs that using sterile syringes is safer than reusing syringes, including syringes that have been disinfected with bleach. The information in this bulletin has been prepared for health professionals involved in programs serving persons who inject drugs. Separate educational materials will be prepared to inform drug injectors of these findings.

* Issued jointly by the Centers for Disease Control and Prevention, the National Institute on Drug Abuse of the National Institutes of Health, and the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration.

** The term "syringes" is used throughout this bulletin to refer to both syringes and needles.

INJECTION DRUG USE AND THE TRANSMISSION OF HIV AND OTHER BLOOD-BORNE INFECTIONS

The reuse and "sharing" of blood-contaminated injection equipment and blood-contaminated dissolved drugs play substantial roles in the transmission of HIV,[2] hepatitis B virus (HBV), hepatitis C virus (HCV),[7] and other blood-borne infections. These infections cause illness and death among drug users, their sex partners, and, through mother-to-infant transmission, their children. More than one third (35%) of all AIDS cases reported in the United States in 1995 were directly or indirectly associated with injection drug use.[8]

Blood is introduced into needles and syringes at the start of every intravenous injection. The reuse of a blood-contaminated syringe by another drug injector (sometimes called "direct syringe sharing") carries a substantial risk of transmission of blood-borne infections, including HIV, HBV, and HCV. In addition, blood and blood-borne infections can be introduced into drug solutions by the use of blood-contaminated syringes to prepare drugs; the reuse of water; the reuse of bottle caps, spoons, or other containers ("spoons" and "cookers") used to dissolve drugs in water and to heat drug solutions; and the reuse of small pieces of cotton or cigarette filters ("cottons") used to filter out particles that could block the needle.[9,10] Multiperson use of contaminated water, dissolved drugs, and drug preparation equipment is sometimes called "indirect sharing."[11]

Because some "street" sellers of syringes repackage used syringes and sell them as sterile syringes,[12] persons who continue to inject drugs should obtain syringes from reliable sources of sterile syringes, such as pharmacies.

In addition to HIV, HBV, HCV and other blood-borne infections, persons who inject drugs are at risk of other serious infections.[13] Use of alcohol swabs to clean the injection site prior to injection has been shown to reduce the occurrence of cellulitis, injection site abscesses, and, possibly, endocarditis among persons who inject drugs.[13,14]

CRITICAL IMPORTANCE OF PREVENTION AND TREATMENT OF DRUG DEPENDENCE

The risks of transmission of blood-borne illnesses are compelling reasons for strengthening public health and community efforts to help persons avoid starting drug injection and to help IDUs stop using drugs. Addiction is a major factor in the use of drugs such as heroin, cocaine, and amphetamines. While the recommendations in this bulletin will help reduce the individual and public health risks associated with injection drug use, the ultimate goals are to prevent at-risk individuals from initiating injection drug use and to help drug injectors stop drug injection through substance abuse treatment and recovery from addiction. For most persons who are addicted to drugs, admission to drug and alcohol treatment programs is a key step in reducing and/or stopping their drug use.

A 1995 WORKSHOP AND RECENTLY PUBLISHED STUDIES AND RECOMMENDATIONS

On February 15-16, 1995, a workshop on the role of sterile syringes in the prevention of HIV transmission among drug users who continue to inject was held at Johns Hopkins University in Baltimore, Maryland. The workshop was sponsored by the Centers for Disease Control and Prevention (CDC), the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute on Drug Abuse (NIDA) of the National Institutes of Health (NIH), and the Johns Hopkins University School of Hygiene and Public Health.

In September 1995, the findings and conclusions of a two-year National Academy of Sciences (NAS) study were published in a report entitled "Preventing HIV Transmission: The Role of Sterile Needles and Bleach."[2] Also in September 1995, the *Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology* published reports of the evaluation of laws enacted in Connecticut in 1992 that allowed the purchase without a prescription and the legal possession of as many as 10 syringes.[3,4]

In 1996, the U.S. Preventive Services Task Force published guidelines recommending that drug users who continue to inject be advised to use sterile syringes and take other steps to prevent health problems associated with injecting drugs.[5] Also in 1996, the American Medical Association published a physician guide to HIV prevention that stated that primary care physicians can help their patients reduce HIV risk from injecting drugs by encouraging them to "Use a new needle and syringe each time drugs are injected."[6]

Based on discussions during the 1995 Johns Hopkins workshop and the findings from these studies, the new recommendations for drug users who continue to inject drugs include: (1) substance abuse treatment to reduce or eliminate drug injection; (2) the use of sterile syringes to reduce the spread of blood-borne infections; (3) the use of new, ideally, sterile water and equipment to prepare drugs; and (4) adequate disinfection of the injection site by drug users to prevent local infection and endocarditis.

IMPLICATIONS OF NEW INFORMATION ON HIV RISKS ASSOCIATED WITH DRUG INJECTION

To minimize the risk of disease transmission, persons who continue to inject drugs should be advised to always use sterile injection equipment; warned never to reuse needles, syringes, and other injection equipment; and told that using syringes that have been cleaned with bleach or other disinfectant is not as safe as using new, sterile syringes. The NAS report stated: **"For injection drug users who cannot or will not stop injecting drugs, the once-only use of sterile needles and syringes remains the safest, most effective approach for limiting HIV transmission."**[2] CDC recommends that all syringes used for parenteral injections be sterile.[15] Drug preparation equipment, such as "cottons," "cookers," water, and syringes should not be reused because they are usually

contaminated with blood. Most syringes and needles used by drug injectors were not designed for reuse. Boiling needles and syringes for 15 minutes between uses can disinfect the equipment. However, boiling may alter the shape and functioning of the plastic syringes widely used by drug injectors in the United States. Disinfecting previously used needles and syringes with bleach (or other chemicals) can reduce the risk of HIV transmission, but using disinfected syringes is not as safe as using a new, sterile needle and syringe.[16] The NAS report found that bleach disinfection (using the procedures described in the April 1993 NIDA, CSAT, CDC bulletin on bleach) is likely to be effective but ". . . is clearly an intervention to be used when injection drug users have no safer alternatives."[2]

PROVISIONAL RECOMMENDATIONS TO DRUG USERS WHO CONTINUE TO INJECT

Health care workers involved in programs that serve drug users should communicate the following recommendations to drug users who continue to inject. Adhering to these drug preparation and injection procedures will reduce the public health and individual health risks associated with drug injection for both drug users and other persons in their communities.

Persons who inject drugs should be regularly counseled to:

I. **Stop using and injecting drugs.**

II. **Enter and complete substance abuse treatment, including relapse prevention.**

III. **Take the following steps to reduce personal and public health risks, if they continue to inject drugs:**

Never reuse or "share" syringes, water, or drug preparation equipment.

Use only syringes obtained from a reliable source (e.g., pharmacies).

Use a new, sterile syringe to prepare and inject drugs.

If possible, use sterile water to prepare drugs; otherwise use clean water from a reliable source (such as fresh tap water).

Use a new or disinfected container ("cooker") and a new filter ("cotton") to prepare drugs.

Clean the injection site prior to injection with a new alcohol swab.

Safely dispose of syringes after one use.

The availability of new, sterile syringes varies, depending on state and local regulations regarding the sale and possession of syringes and on other factors, such as the existence of syringe exchange programs sponsored by local HIV prevention organizations.[17] If new, sterile syringes and other drug preparation and injection equipment are not available, then previously used equipment should be boiled or

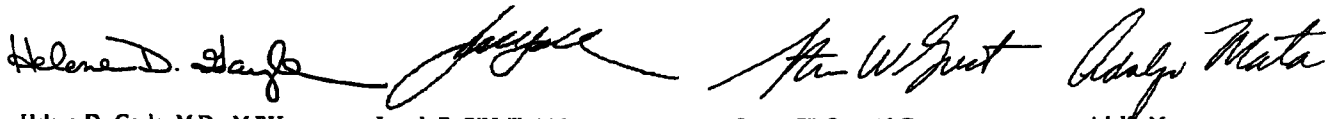
disinfected with bleach using the methods recommended in the April 1993 bulletin.[1]

In addition, drug users should be provided information on how to prevent HIV transmission through sexual contact and, for women, information on reducing the risk of mother-to-infant HIV transmission.

FOR MORE INFORMATION

For more information or to comment on this bulletin, please contact the following staff members of the organizations releasing this bulletin: **CDC** - Dr. T. Stephen Jones at 404-639-5200 (fax 404-639-5260); **HRSA** - Dr. A. Russell Gerber at 301-443-4588 (fax 301-443-1551); **NIDA** - Dr. Steven W. Gust at 301-443-6480 (fax 301-443-9582); and **SAMHSA** - Mr. Adolfo Mata at 301-443-5305 (fax 301-443-3817).

Sincerely yours,



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Substance Abuse and Mental Health Services Administration

REFERENCES:

Single copies of the publications marked with ** and the executive summary of the National Academy of Sciences report are available at no cost from the CDC National AIDS Clearinghouse (1-800-458-5231).

1. CDC, CSAT NIDA Prevention Bulletin April, 1993.**

2. Normand J, Vlahov D, Moses LE, eds. Preventing HIV Transmission: The Role of Sterile Needles and Bleach. Washington, DC: National Academy Press, 1995.

3. Valleroy LA, Weinstein B, Jones TS, et al. Impact of increased legal access to needles and syringes on community pharmacies' needle and syringe sales—Connecticut, 1992-1993. J Acquir Immune Defic Syndr Hum Retrovirol 1995;10:73-81.**

4. Groseclose SL, Weinstein B, Jones TS, et al. Impact of increased legal access to needles and syringes on the practices of injecting-drug users and police officers—Connecticut, 1992-93. J Acquir Immune Defic Syndr Hum Retrovirol 1995;10:82-9.**

5. U.S. Preventive Services Task Force. Guide to clinical preventive services (2nd ed.). Baltimore: Williams & Wilkins, 1996.

6. American Medical Association. A physician guide to HIV prevention. Chicago, Illinois: American Medical Association, 1996.

7. Alter M. Epidemiology of hepatitis C in the West. Sem Liver Dis 1995;15:5-14.

8. CDC. AIDS associated with injecting-drug use—United States, 1995. MMWR 1996;45:392-8.**

9. Koester SK, Booth R, Weibel W. The risk of HIV transmission from sharing water, drug mixing containers, and cotton filters among intravenous drug users. Int J Drug Policy 1990;1:28-30.

10. Jose B, Friedman SR, Curtis R, et al. Syringe-mediated drug-sharing (backloading): a new risk factor for HIV among injecting drug users. J Acquir Immune Defic Syndr 1993;7:1653-60.

11. Koester SK, Hoffer L. "Indirect sharing": additional HIV risks associated with drug injection. AIDS & Public Policy Journal 1994;9:100-105.

12. Des Jarlais DC, Friedman SR, Hopkins W. Risk reduction for the acquired immunodeficiency syndrome among intravenous drug users. Ann Intern Med. 1985;103:755-9.

13. Spijkerman IJB, Vanameijden EJC, Mientjes GHC, Coutinho RA, Vandenhoek A. Human immunodeficiency virus infection and other risk factors for skin abscesses and endocarditis among injection drug users. J Clin Epidemiol.1996;49:1149-1154

14. Vlahov D, Sullivan M, Astemborski J, Nelson KE. Bacterial infections and skin cleaning prior to injection among intravenous drug users. Public Health Rep 1992;107:595-8.

15. CDC. Improper infection-control practices during employee vaccination programs—District of Columbia and Pennsylvania, 1993. MMWR 1993;42:969-71.

16. Haverkos HW, Jones TS. HIV, drug-use paraphernalia, and bleach. J Acquir Immune Defic Syndr 1994;7:741-2.**

17. Gostin LO, Lazzarini Z, Jones TS, Flaherty K. Prevention of HIV/AIDS and other blood-borne diseases among injection drug users: A national survey on the regulation of syringes and needles. JAMA 1997:277:53-62.**

Revised May 30, 1997

COMMUNITY REFERRAL RESOURCES

MEDICAL SPECIALIST	NAME	ADDRESS	PHONE
Family Practitioners OB-GYN Urologists Pediatricians Dermatologists			
• FAMILY PLANNING CLINICS			
• FREE CLINICS			
• MENTAL HEALTH SERVICES: Counseling Substance Abuse Services Support Group			
• CLERGY			
• COLPOSCOPY CLINICS			
• FERTILITY CLINICS			
• RAPE CRISIS CENTERS			
• AIDS SERVICES ORGANIZATIONS			
• RYAN WHITE CONSORTIA			
• HOT LINES			
• RESEARCH PROTOCOLS			
• INTERPRETERS			
• SIGNERS (sign lanquage resources)			
• HOUSING			
• DOMESTIC VIOLENCE PREVENTION			
FOOD BANK			

Important Toll Free Numbers

Listed below are a few of the National Hotline Numbers that can provide you with more information on HIV/STDs. Calls are free and confidential.

Virginia HIV/STD and Viral Hepatitis Hotline
English service (Monday through Friday. 8am-7pm) 1-800-533-4148 (Voice/TDD)

CDC National AIDS Hotline:

* English service (7 days a week, 24 hours a day) 1-800-342-AIDS (2437)
* Spanish service (7 days a week, 8 a.m. - 2 a.m. eastern time) 1-800-344-7432
* Indian service 1-800-283-AIDS (2437)
* Health Care Worker 1-800-548-4659
* TDD service for the deaf 1-800-243-7889
(10 a.m. til 10 p.m. eastern time, Monday through Friday)
* TTY service for the hearing impaired 1-800-AIDS-TTY or 1-800-243-7889

National STD Hotline 1-800-227-8922

National Herpes Hotline 1-919-361-8488

Herpes Resource Center 1-800-230-6039

National AIDS Clearinghouse 1-800-458-5231

National Institute on Drug Abuse Hotline
English service 1-800-662-HELP (4357)
Spanish service 1-800-66-AYUDA (662-9832)

National Clearinghouse for Alcohol and Drug Information
1-800-SAY-NO-TO (1-800-729-6686)

AIDS Clinical Trials Information Service (ACTIS)
1-800-874-2572 or 1-800-TRIALS-A

Project Inform (San Francisco AIDS Foundation) 1-800-822-7422

Nutrition Hotline 1-800-366-1655

AIDS Treatment Hotline 1-800-822-7422

Talk Line for Teens	1-800-TLC-TEEN
American Liver Foundation	1-888-4HEP-ABC
Hepatitis C Education and Support	1-888-437-2376

Internet Sites

Virginia Department of Health
www.vdh.state.va.us

Center for Disease Control and Prevention (CDC)
www.cdc.gov

CDC Division of HIV Prevention
www.cdc.gov/nchstp/hiv_aids/dhap

CDC National AIDS Clearinghouse
www.cdcnac.org

American Social Health Association under the Center for Disease Control and Prevention
www.ashastd.org/nah/tty.html

United States Government- gateway to health and human services information from the U.S. Government
www.healthfinder.gov

National AIDS Treatment Project- extensive topics related to medical treatment of HIV funded by the Henry J. Kaiser Family Foundation
www.kff.org/archive/aids_hiv/natip/html

Test Positive Aware Network- Publishers of *Positively Aware* offer information and support to allow people with HIV to retain control over their lives.
www.tpan.com

World Health Organization- Access to World Health Report. Weekly Epidemiological Record, WHO publications and library service.
www.who.org

Minority and HIV Resources
www.hivinsite.ucsf.edu/topics

HIV Positive.com- can access information on HIV and its effects.
www.hivpositive.com

ANONYMOUS TESTING SITES

o NORTHWEST VIRGINIA

Charlottesville Health Department
1138 Rosehill Drive
Charlottesville, Virginia 22903
(804) 972-6217
Testing: Wednesday (*10:00 a.m. -12:00 noon),Thursday 9:00 a.m. - 5:00 p.m. **(Appointment only)**
Wednesdays 1:00 p.m. - 4:00 p.m. **(Walk-ins)**
*** As of July 31, 1996, the Wednesday morning hours will be discontinued.**

Fredericksburg Health Department
608 Jackson Street
Fredericksburg, Virginia 22401
(540) 899-4110 (8:00 a.m. - 4:30 p.m. Monday - Friday)
Testing: 1st and 3rd Wednesdays 5:30 p.m.- 6:30 p.m. **(Appointment only)**
Monday and Thursday 9 a.m. - 12:30 p.m.; 2nd, 4th and 5th Wednesdays 1:00 p.m. - 4:00 p.m.; 1st and 3rd Wednesdays 1:00 p.m. - 5:30 p.m. **(Walk-in)**

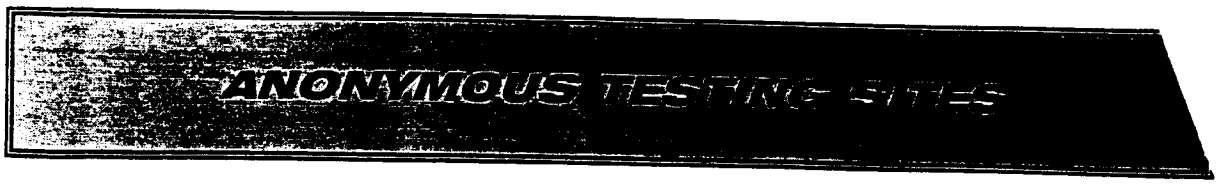
Rockingham/Harrisonburg Health Department
110 North Mason Street
Harrisonburg, Virginia 22801
(540) 574-5220 (9:00 a.m. - 4:30 p.m. Monday - Friday)
Testing: Tuesdays 5:30 p.m. - 8:45 p.m. **(Appointment only)**

Winchester Health Department
150 Commercial Street
Winchester, Virginia 22601
(540) 662-0559 (9:00 a.m. - 1:00 p.m. Monday - Friday)
Testing: Wednesday 4:30 p.m. - 7:30 p.m. **(Appointment only)**

o NORTHERN VIRGINIA

Alexandria Health Department
517 North Saint Asaph Street
Alexandria, Virginia 22314
(703) 838-4388 or 838-4389 (8:30 a.m.-5:00 p.m. Mon - Fri)
Testing: Thursday 5:00 p..m - 6:30 p.m. **(Appointment only)**
(Walk-ins accepted as time permits).

Arlington Department of Human Services
1800 North Edison Street
Arlington, Virginia 22207
(703) 358-5200 (8:00 a.m. - 5 p.m. Monday - Friday)
Testing: Wednesday, 1:15 p.m. - 4:15 p.m. (Appointments only)
Tuesday 4:00 p.m. - 6:00 p.m. and Thursday 1:30 p.m. - 2:30 p.m. (Walk-ins only)



Fairfax County Health Department
Joseph Willard Health Center
3750 Old Lee Highway
Fairfax, Virginia 22030
(703) 246-7100 (8:00 a.m. - 4:30 p.m. Monday - Friday)
Testing: Tuesday 6:00 p.m. - 7:00 p.m. (Walk-in)

Prince William Health Department
Manassas Office
9301 Lee Avenue
Manassas, Virginia 22110
(703) 792-6300 (8:00 a.m. - 4:30 p.m. Monday - Friday)
Testing: Alternating Tuesdays 6:00 p.m. - 9:00 p.m. (Appointment only)

Woodbridge/Garfield Office
13792 Smoketown Road
Woodbridge, Virginia 22192
(703) 792-7300 (8:00 a.m. - 5:00 p.m. Monday - Friday)
Testing: Alternating Thursdays 6:00 - 9:00 p.m. (Appointment only)

SOUTHWEST VIRGINIA

Henry-Martinsville Health Department
295 Commonwealth Boulevard
Martinsville, Virginia 24114
(540) 638-1804 (8:15 a.m.- 5:00 p.m. Monday - Friday)
Testing: Tuesday 5:00 p.m. - 7:30 p.m. (Walk-in)

Roanoke City Health Department
515 8th Street, S.W.
Roanoke, Virginia 24016
(540) 857-7600 (8:00 a.m. - 5:00 p.m. Mon. - Fri.)
Testing: Monday 3:00 p.m. - 6:00 p.m. (Walk-in)

Montgomery County Health Department
401 Depot Street N.W.
Christiansburg, Virginia 24073-2011
(540) 381-7105 (8:00 a.m. - 4:30 p.m. Monday - Friday)
Testing: Monday 5:00 p.m. . - 7:00 p.m. (Walk-in)

Washington County Health Department
234 West Valley Street
Abingdon, Virginia 24210
(540) 628-9255 (8:00 a.m. - 4:30 p.m. Monday - Friday)
Testing: Mondays 4:30 p.m. - 7:00 p.m., Tuesdays 1:00 p.m. - 4:00 p.m., Fridays 8:00 a.m. - 4:00 p.m. (Walk-in)

Wythe County Health Department
750 West Ridge Road
Wytheville, Virginia 24382
(540) 228-8629 (8:00 a.m. - 4:30 p.m. Monday - Friday)
Testing: Usually second & fourth Thursdays 4:30 p.m. - 7:00 p.m. (Walk-in)

ANONYMOUS TESTING SITES

o CENTRAL VIRGINIA

Medical College of Virginia
Richmond, Virginia 23219
(804) 828-2210 (8:00 a.m. - 5:00 p.m. Monday - Friday)
Testing: *10:00 a.m. - 2:00 p.m. Tuesday - Thursday (*Testing hours vary)

Cross Over Health Services
108 Cowardin Avenue
Richmond, Virginia 23224
(804) 233-5016 (9:00 a.m. - 5:00 p.m. Monday - Friday)
Testing: Monday, Tuesday, Thursday 4:00 p.m. - 4:45 p.m. (Appointment only)

Petersburg
(804) 732-7261 (8:15 a.m. - 5:00 p.m. Monday - Friday)
Testing: Alternating Wednesdays 5:15 p.m. - 6:45 p.m. (Appointment only)

South Boston
(804) 476-4868 or (804) 476-4863) (8:30 a.m. - 4:30 p.m. Monday - Friday)
Testing: Monday 4:30 p.m. - 6 p.m. (Appointment only)

o EASTERN VIRGINIA

Hampton Health Department
3130 Victoria Boulevard
Hampton, Virginia 23661
1-800-873-TEST (9 a.m. - 5:00 p.m. Monday - Friday)
Testing: Wednesday 5:00 p.m. - 7:45 p.m. (Appointment only)

Norfolk Community Hospital
2539 Corprew Avenue (visitor's entrance)
Norfolk, Virginia 23504
1-800-873-TEST (9 a.m. - 5:00 p.m. Monday - Friday)
Testing: Monday 5:15 p.m. - 7:45 p.m. (Appointment only)

Virginia Beach Health Department
Virginia Beach Human Resource Building
3432 Virginia Beach Boulevard
Virginia Beach, Virginia 23452
1-800-873-TEST (9 a.m. - 5:00 p.m. Monday - Friday)
Testing: Monday and Thursday 5:30 p.m. - 8:30 p.m. (Appointment only)

Portsmouth Health Department
800 Crawford Parkway
Portsmouth, Virginia 23703
1-800-873-TEST (9 a.m. - 5 p.m. Monday - Friday)
Testing: Tuesdays 5:30 p.m. - 8:30 p.m. (Appointment only)

GLOSSARY

acute	Of short duration.
adhesions	Scar tissue that may form between structures during an infection.
adnexa	Uterine appendages, including the tubes, ovaries, and parametrium.
agglutinins	Antibodies that cause clumping of microorganisms.
allergic reaction	A reaction that results from extreme sensitivity to a drug or an agent and that is not dependent on the amount of drug given. These reactions may be classified into two types, immediate and delayed, according to the time it takes for the reaction to occur.
alopecia	Absence or loss of hair. In secondary syphilis, this temporary hair loss is patchy, giving a "moth-eaten" appearance, and may include loss of eyebrow hair.
ampulla	The junction of the vas deferens and the seminal vesicle.
anaphylaxis	The most serious form of immediate allergic reaction, capable of causing death. Occasionally occurs as a result of penicillin therapy.
aneurysm	A saccular ballooning of the walls of an artery or a vein.
annular	Circular.
anterior cul-de-sac	Pocket in the abdominal cavity between the uterus and the bladder.
anterior fornix	Pocket within the apex of the vagina, between the bladder and the cervix.
antibiotic	A chemical substance capable of destroying bacteria and other microorganisms.
antibody	A type of serum protein that is produced by the body in response to foreign antigens. Antibodies assist the body in removing or destroying foreign antigens.
antigens	Foreign substances that stimulate the body to produce antibodies. Such substances may be used to detect antibodies in the serum.
anus	Opening to the rectum.
aortitis	Inflammation of the aorta.
arthritis	Inflammation of the joints and the surrounding tissues.

chancre	The initial sore, or lesion, of primary syphilis; occurs at the site of entry of *Treponema pallidum*.
Charcot's joint	A manifestation of late syphilis caused by loss of normal sensation in the knees and subsequent traumatic destruction of the joint.
Chlamydia trachomatis	The causative organism of lymphogranuloma venereum, chlamydial urethritis, and most cases of newborn conjunctivitis.
chorioamnionitis	Inflammation of fetal membranes caused by bacterial infection.
chronic	Of long duration.
clitoris	Small, sensitive, erectile organ at the upper end of the vulva.
cluster interview	An interview with a noninfected sex partner, a suspect, or an associate; designed to elicit the name of STD patients or suspected STD patients.
Clutton's joints	Painless, symmetric swelling, especially of the knee joints. Often seen in infants with congenital syphilis and in adults with tabes dorsalis.
communicable	Capable of spreading from one diseased person or animal to another person or animal, either directly or indirectly.
condylomata acuminata	A form of warts of the anogenital area (of viral origin).
condylomata lata	Moist, flat, wart-like lesions that usually appear in the anogenital area; a sign of secondary syphilis and highly infectious.
congenital	Acquired by the newborn before birth.
conjunctivitis	Inflammation of the surfaces of the eye and the eyelid. May be caused by a chlamydial or a gonococcal infection.
contraindication	Any condition that renders a particular treatment improper or undesirable. For example, pregnancy is a contraindication for treatment with tetracycline.
Cowper's gland	In male anatomy, a gland that produces lubricating fluids during intercourse.
cunnilingus	Oral stimulation of the female genitalia.
cutaneous	Having to do with the skin.
cystitis	Inflammation of the bladder.
cytomegalovirus	A herpes-like virus that affects the immune system and is particularly dangerous to neonates.

epidemiology The study of the factors that influence the spread of disease in an area.

epididymis The elongated, cord–like structure along the posterior border of the testes, in the ducts of which the spermatozoa are stored.

epididymitis Inflammation of the epididymis.

epithelium The covering of internal and external surfaces of the body. It consists of cells and is classified into types on the basis of the number of layers in depth and the shape of the cells.

erectile body The penile structure that stiffens to create an erection.

erythema Redness of the skin, which may result from a variety of causes.

etiologic agent The organism that causes a disease.

etiology The study of all the causes of a disease. In practice, etiology represents the sum of factual and theoretic knowledge about causation.

expected–in file A file containing forms that tell which patients DIS expect to come into the clinic, and why that patient is expected. This file should be checked for each registrant whether or not the person claims to have been referred.

extracellular Outside the cell wall.

fallopian tube A slender tube extending from the ovary to the uterus. Eggs released during ovulation pass through this tube to reach the uterus. The normal site of fertilization, it is often damaged by Pelvic Inflammatory Disease (PID).

false positive A reactive test result caused by a disease or a condition other than the disease for which the test is designed.

fellatio Oral sex involving the penis.

foreskin Fold of skin that, in uncircumcised men, covers the glans penis.

friable Fragile, easily crumbled, especially prone to bleeding; for example, cervical tissue in some infections.

genitourinary Pertaining to the urinary and the reproductive structures; sometimes called the GU tract or system.

glans penis The head of the penis.

gonococcus The specific etiologic agent of gonorrhea, a microorganism discovered by Neisser and named *Neisseria gonorrhoeae*.

intracellular	Found within the cell.
in utero	In the uterus.
in vitro	In a test tube.
in vivo	In the living body.
Jarisch–Herxheimer reaction	Sudden fever or inflammation of syphilis lesions; occurs after treatment for syphilis. Caused by the rapid killing of many treponemes, the reaction rarely lasts for more than 24 hours.
Kassowitz' law	The longer the duration of the untreated infection before pregnancy, the less likely the fetus will be stillborn or infected.
labia minus	Fleshy inner boarder of the vagina.
Langhan's cell layer	Cellular layer of the early placenta that begins to atrophy after the fourth month of pregnancy and disappears after the sixth month. The cells were once believed to protect the fetus from infection.
laparoscopy	Visualization of the peritoneal area through an instrument inserted through a small incision in the abdominal wall.
latency	The period when no symptoms are present. In early syphilis, this can occur between the primary stage and the secondary stage, or after the secondary stage. Laboratory tests at this time are usually positive.
locomotor ataxia	Syphilis of the spinal cord in which the patient's gait becomes clumsy and uncoordinated.
lot system	A process that promotes case management and helps workers to analyze thoroughly, make effective decisions, and take advantage of every opportunity to advance disease intervention.
lumbar puncture	The procedure used for collecting cerebrospinal fluid.
lymph nodes	Gland–like structures in the lymphatic system that help to prevent spread of infection.
lymphatic system	A fluid system of vessels and glands that is important in controlling infections and limiting their spread.
macule	A discolored spot or patch on the skin that is neither elevated above the surface nor thickened.
malaise	A vague feeling of bodily discomfort or uneasiness; an out–of–sorts feeling, often the first indication of infection or disease.

osteochondritis	Inflammation of the bone and surrounding cartilage.
ovary	Gland that produces ova (eggs) and hormones.
papule	Elevated skin lesion.
papulosquamous	Both papular (raised) and squamous (scaly, or plate-like).
paresis	Slight or incomplete paralysis; a manifestation of late neurosyphilis that results in insanity.
pathogenic	Giving origin to disease or causing symptoms.
pathology	The science of the essential nature of diseases, especially of the structural and functional changes in tissues and organs of the body that are caused by disease.
penicillinase	An enzyme that is produced by certain bacteria and that destroys penicillin.
perianal glands	Glands located around the anus.
perihepatitis	Inflammation of the liver and the surrounding tissues.
perineal body	The connection between the opening of the vagina and the anus.
peritoneum	Epithelial lining of the abdominal cavity.
peritonitis	Inflammation of the epithelial lining of the abdominal cavity.
pharyngeal	In the back of the throat; pertaining to the pharynx.
Pthirus pubis	Commonly known as pubic louse or crab, obligate parasite of humans.
PID	Pelvic inflammatory disease. Inflammation of the female pelvic organs; often the result of gonococcal or chlamydial infection.
plasmid-mediated	Modified by the development of a cell component (extrachromosomal material) that changes the biochemistry of a cell.
polymorphonuclear leukocyte (PMN)	A type of white blood cell having a multilobulated nucleus.
postcoital	After sexual intercourse.
posterior fourchette	The fold of mucous membrane at the posterior junction of the labia majora.
posterior fornix	Pocket within the apex of the vagina, between the rectum and the cervix, where vaginal and cervical discharge accumulate during pelvic examination.

saber shin	The anterior or frontal bowing of the shin bone, which is a possible stigma of congenital syphilis.
saddle nose	A stigma of congenital syphilis indicated by a flattened bridge of the nose.
salpingitis	Inflammation of the fallopian tube: often used as a synonym for PID.
Sarcoptes scabiei	The itch mite which causes scabies.
scrotum	The sac containing the testes.
selective media	Liquid or solid laboratory culture material containing inhibitory substances that allow the growth of the desired microorganism while inhibiting the growth of contaminants. For example, modified Thayer–Martin medium is a selective medium for *N. gonorrhea.*
self–inoculation	The introduction of microorganisms from one's own body.
seminal vesicle	The structure containing the seminal fluid.
sensitivity	A test's ability to react in patients who have the disease the test is designed to reveal.
septicemia	A condition in which an infectious agent has spread throughout the lymphatic and blood systems; causes a general body infection.
sequela	Any health consequence (physical or mental) of a disease.
serofast	The failure of reagin to disappear despite adequate treatment.
serologic test	Laboratory tests made on serum.
serum	The clear liquid that separates from the blood when it is allowed to clot; it is used in most serologic tests.
silver nitrate	Caustic fluid placed in the newborn's eyes to prevent ophthalmia neonatorum.
snuffles	A heavy mucoid discharge of the nose and the pharynx in infants; may be due to congenital syphilis.
specificity	A test's ability to give true negative results in the absence of the disease that the test is designed to reveal.
spirochete	Treponeme, a corkscrew–shaped organism.
spongy body	One of two soft tissue structures that run the length of the penis and that become engorged with blood during an erection.

treponeme	Parasitic and pathogenic spiral microorganism.
Treponema pallidum	A spiral–shaped microorganism that causes syphilis.
Trichomonas vaginalis	The causative agent of trichomoniasis.
ureter	The tube connecting the kidney to the bladder.
urethra	The tube through which urine is discharged.
urethral strictures	Scar tissue that can block the urethra.
urethritis	Inflammation of the urethra.
uterus	The womb; a pear–shaped, muscular organ that holds the fetus during pregnancy.
vagina	The canal that leads from the external female genitalia to the cervix.
vaginal introitus	Opening to the vagina; located between the urethral meatus and the anus, and surrounded by the labium majus and the labium minus.
vas deferens	Tube that transports sperm from the testes to the ejaculatory duct.
venereal warts	Verruca acuminata, or condylomata acuminata; of viral origin; the "pointed" form of condylomata on, or near, the anus or the genitals.
vesicle	A small blister on the skin.
virulence	The ability of an infectious agent to induce, incite, or produce pathogenic changes in the host.
vulva	The external parts of the female genital organs.

Miscellaneous

This section of the HIV/STD Operations Manual is provided so that local Health Districts may include District specific information for their staff as appropriate.